Section C. QUALITY OF CARE AND SERVICES

A Section 1915(b) waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, 1915(b) waiver programs which utilize MCOs or PHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submittal will document how the State has monitored and plans to meet these requirements.

I. Elements of State Quality Strategies: -- This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

Previous Waiver Period

a.___ During the last waiver period, the Elements of State Quality Strategies were different than described in the waiver governing that period. The differences were:

b.__x__ [Required] Describe the results of monitoring MCO/PHP adherence to State standards for internal Quality Assurance Programs during the previous two-year period [item C.I.b in 1999 initial preprint; Item B.1 in 1995 preprint].

Quality Management was another of the three specific areas of focus for on-site monitoring in the last three years. As such during the visits of the QA&I team to the local area there were questions directed specifically at quality management. Those may be found in Attachment BVIa.

The monitoring teams of the mental health division have consistently pressed hard at multiple levels over several years to enhance the quality of care. There has been a tremendous focus on developing and improving quality management strategies and structures, which has resulted in the beginning of establishment of benchmarks from which to measure improvements in a quantifiable manner. MHD is beginning to realize fruits of these efforts as we have seen increased consumer satisfaction on a statewide level through various monitoring activities and consumer surveys.

MHD continues to promote consumer voice, normalization, reintegration, and recovery. At both the administrative review and the medical audit there has been marked improvement in quality of care for consumers. At the administrative level quality management system is incorporating the recommendations of consumers, the Advisory Board, the QRTs, the Ombuds, community stakeholders and the findings of the MHD review into their overall planning and also in their training development.

Statewide, the RSNs are getting demonstrating increase inclusion of natural support involvement and cross-system involvement. While most charts reviewed are classified as

standard there is an increasing number of exemplary cases. The QA & I team defines the levels as:

Minimum - meets minimal expectations
Standard - meets expectations
Exemplary - exceeds expectations.

QA&I can find cases where there is strong consumer and natural support involvement and those with excellent cross-system collaboration. These are the ones where care is flexible and meet the addressed needs of the consumer. These cases most often receive exemplary.

There is still work to do in the system. The last year of the current waiver cycle, the QA & I team combined the findings of the license review into the report issued on the PHP. These general findings include:

- Lack of consumer voice in treatment planning;
- Poorly addressing needs in other life domains such as housing, health, dental, work, etc.;
- Lack of individualized services.

It is important to note that a particular finding may apply in only one of the many community mental health centers in the service area of the RSN. Nonetheless, the RSN is required to review and follow-up on the corrective action plan of the agency as it is submitted to the MHD. This increased communication between the licensing activity and the RSN is a positive increase in the quality of care in the system.

** One major area identified by the MHD for work at both the MHD and RSN level for the next waiver period is the development of a clear RSN system picture both clinically and administratively. While the RSN can identify at each community mental health center the strengths and challenges, they struggle to do the same on a network-wide basis. The same is true of the MHD. It is easy to point to strengths and challenges in each RSN but the clarity weakens as the statewide picture develops. The intended use of performance indicators over the next two years should begin to help define statewide clarity.

Other information may be found in the reports submitted to CMS as part of Special Terms and Condition # 2, 3, 4 & 5 throughout the waiver period.

c.___ [Required for MCOs] Summarize the results of reports from the External Quality Review Organization. Describe any follow-up done/planned to address study findings [item C.I.c in 1999 initial preprint; item B.2 in 1995 preprint].

d.__x__ [Required for PHPs and MCOs] Describe the results of periodic medical audits, and any follow-up done/planned to address audit findings [item C.I.d in 1999 initial preprint; item B.3 in 1995 preprint].

The QA & I team follows-up year to year on corrective actions and quality improvement recommendations. There have been some instances where the MHD has requested technical

assistance to help either the RSN or the provider network to come into compliance. In the instances where there were many issues with licensing and/or certification the team has returned in 30-120 days for follow-up visits.

Corrective actions have been issued for:

- Treatment planning not done with the consumer;
- Treatment goals and time frames were not set;
- Timely access to specialists;
- Not addressing consumer needs across life domains;
- Not providing for the required 180-day review;
- Long periods of time between initial screening and access to ongoing services;
- Consumer rights not posted or made known to the consumer; and,
- Not engaging families and natural supports.

Corrective actions due in this waiver period have been received and approved by the MHD. Follow-up visits to the provider have shown marked improvement and, as they have done in the past, the QA&I team will revisit this year's findings during their next on-site visit.

e._____ [MCOs only] Intermediate sanctions were imposed during the previous waiver period. Please describe.

Upcoming Waiver Period -- Please check any of the items below that the State requires. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Note: Elements a - g are requirements for States. Elements c, d and e are required for States which contract with MCOs and element d is required for States which contract with PHPs. The State:

a.__x__ Includes in its contracts with MCOs/PHPs, the State-required internal QAP standards. Please submit a copy of the State's Quality Assurance and Performance Improvement (QAPI) standards and/or guidelines currently required of MCOs/PHPs in their contracts as an attachment to this section (Attachment C.I.a).

The following are contract terms from the 01-03 contract.
The Contractor shall ensure Quality Management (QM) activities comply with all applicable law and standards including, but not limited to: WAC 388-865-0280, -0425; the MHD-approved QM Plan; or any successors. In addition, the Contractor shall:

- Establish mechanisms to ensure compliance with this Agreement including monitoring on a regular basis to determine compliance and taking remedial action if there is a failure to comply.
- Conduct all monitoring and review activities necessary to carry out the QM Plan and determine the effectiveness of the overall regional system of care.
- Ensure the capacity, access, and use of appropriate mental health professionals and mental health specialists.
- Assure mental health specialists are involved at critical treatment junctures.

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- Ensure participation and compliance with grievance, fair hearings, and disenrollment determinations. In cases where determinations have broader system implications, those determinations shall be the basis for system quality improvements.
- Perform a biennial satisfaction survey of the Contractor's provider network, including allied systems and local stakeholders, using a standardized format provided by the MHD. The Contractor shall include data from the satisfaction survey for planning and system improvement.
- Ensure the interpretation of Quality Assurance and Quality Improvement data in feedback to providers.
- Ensure access, quality, and appropriateness of services by assessing the following at a minimum:
- The clinical appropriateness or fit between what was needed and what was received;
- The degree to which services provided are driven by consumer needs;
- The effectiveness of mechanisms to detect both underutilization and overutilization of services;
- The effectiveness of mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs;
- The degree to which services and planning incorporate the consumer/family voice;
- The degree to which services and planning are age, culturally, and linguistically competent;
- The degree to which services are provided in the least restrictive environment;
- The degree to which needs for housing, employment and education options were assessed;
- The degree to which there was inclusion, recruitment and use of natural supports and other community resources;
- The degree to which there are appropriate linkages and integration with other formal/informal systems and settings;
- The degree to which there was congruence between the chart including assessment, individual service planning, and progress notes, with the actual services and supports provided;
- Performance regarding service delivery within current standards of mental health;
- Services/systems include adequate triage for all settings of care (inpatient, emergency crisis intervention services, community support services);
- Continuity of care within and across services;
- Compliance with policies regarding the use of advance directives for psychiatric care;
- Competence in the workforce (e.g. appropriate training, licensure, supervision, and clinical oversight of staff employed or contracted by providers).
- Ensure performance and efficiency of service provider network including:
- Integration of administration, management processes, and service delivery;
- Fiscal reporting and monitoring processes appropriate to fiscal management terms of this Agreement;
- Compliance with other administrative/management requirements of this Agreement; and
- Implementation of a peer review process.

The template for the MHD's quality Management Plan and the templates produced for use by the RSNs in developing their Quality Management Plan, Marketing Plan and Grievance Plan under this waiver period are attached as Attachment CIa.

b. __x__ Monitors, on a continuous basis, MCOs/PHPs adherence to the State standards, through the following mechanisms (check all that apply):

1. __x__ Review and approve each MCOs/PHPs written QAP. Such review shall take place prior to the State's execution of the contract with the MCO/PHP.

2. __x__ Review each MCOs/PHPs written QAP on a periodic schedule after the execution of the contract. Please specific frequency:

At least once a biennium and when any changes are made.

3. __x__ On-site (MCO/PHP administrative offices or service delivery sites) monitoring of the implementation of the QAP to assure compliance with the State's Quality standards. Such monitoring will take place (specify frequency) annually for each MCO/PHP or attach the scope of work from the EQRO contract as an attachment to this section.

The RSN administrative structure is monitored annually by the QA&I team as is the provider network for the required medical audit. One of the recommendations of SIG 1 is to look at giving some monitoring relief to the administrative structure based on consistent exemplary findings. This is a recommendation that may be considered by a new SIG group.

4. _x_ Conducts monitoring activities using (check all that apply):

(a) _x_ State Medicaid agency personnel *(joined by two independent master level therapists and a consumer or parent representative)*

(b) ___ Other State government personnel (please specify):

(c) __ A non-State agency contractor (please specify):

5. _x_ Other (please specify):

MHD will offer the recommendation of the SIG 2 of expanding the QA&I peer review by other RSN/provider network staff joining annual on-site visit.

c. ____ Will arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to items and services delivered under each MCO contract with the State. Note: Until additional guidance on EQR is released,

please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area.

1. Please specify the name of the entity:

2. The entity type is:
(a)__A Peer Review Organization (PRO).
(b)__A private accreditation organization approved by HCFA.
(c)__A PRO-like entity approved by HCFA.

3. Please describe the scope of work for the External Quality Review Organization (EQRO):

d._x_ Has established a system of periodic medical audits of the quality of, and access to, mental health care for each MCO/PHP on at least an annual basis. These audits will identify and collect management data (including enrollment and termination of Medicaid enrollees and utilization of services) for use by medical audit personnel. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area. States may, at their option, institute EQR reviews for PHPs. These periodic medical audits will be conducted by:

1. The entity type is:
(a)_x_State Medicaid agency personnel *(joined by two independent master level therapists and a consumer or parent representative.)*
(b)__Other State government personnel (please describe):
(c)__A non-State agency contractor to the State (please describe):
(d)__Other (please describe):

2. Please attach the scope of work for the periodic medical audits.

The monitoring schedule for this biennium needs to be verified with the RSNs and checked against major system events for conflicts. The monitoring and licensing tools will be updated over the summer and fall of 2001 to be consistent with the new WAC, contract and waiver renewal and will be submitted to CMS Region X upon their completion. With the delays and uncertainty in the regulations of the BBA and the MHD's contracting cycle development of new tools has been in flux.

e.__ Has established intermediate sanctions that it may impose if the State makes a determination that an MCO violates one of the provisions below. (Note: does not apply to PHPs).

f._x_ Has an information system that is sufficient to support initial and ongoing operation and review of the State's QAPI.

g. x Has standards in the State QAPI, at least as stringent as those required in federal regulation, for access to care, structure and operations, quality measurement and improvement and consumer satisfaction.

h.__ Plans to develop and implement the use of QISMC in its quality oversight of MCOs/PHPs? (QISMC is a HCFA initiative to strengthen MCOs/PHPs' efforts to protect and improve the health and satisfaction of Medicare and Medicaid enrollees. The QISMC standards and guidelines are key tools that can be used by HCFA and States in implementing the quality assurance provisions of the Balanced Budget Act (BBA) of 1997. This is strictly a voluntary initiative for States) Please explain which domains will the State be implementing (check all that apply).

1.__ Domain 1 - Quality Assessment and Performance Improvement (QAPI) Program: Date of Implementation _____

2.__ Domain 2 - Enrollee Rights: Date of Implementation _____

3.__ Domain 3 - Health Services Management : Date of Implementation _____

4.__ Domain 4 - Delegation: Date of Implementation _____

i.__ Other (please describe):

II. Coverage and Authorization of Services

Previous Waiver Period

a.___ During the last waiver period, coverage and authorization of services were different than described in the waiver governing that period. The differences were:

b. x [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of authorization of services and under/over utilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period.

All Medicaid eligibles have coverage. Mental health services are voluntary unless court ordered therefore, authorization for service is more of utilizing level of care guidelines that have been developed by the RSNs and approved by the MHD.

As a result of SIG 2, this is an area where MHD relies on the RSN for monitoring their provider network to avoid duplication. Resource Management and Utilization management

could not be delegated to the provider of services except to the lowest level of care (brief intervention). QA & I monitor to see there is authorization numbers in the chart, that services are according to treatment plan, that the treatment plan is equal to the level of intake. QA & I will continue to do random checks of the RSN monitoring.

Monitoring reports that include both the on-site findings of the QA & I team but the annual and semi-annual reports required as contract deliverables have been sent as part of Special Terms and Conditions number 2 & 4. These reports have not included any corrective actions of either the RSN or the provider network on areas of authorization of services per the level of care guidelines approved.

Upcoming Waiver Period -- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs meet coverage and authorization requirements. For items a through e, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Contracts with MCOs/PHPs:

a. x Identify, define and specify the amount, duration and scope of each service offered, differentiating those services, which may be only available to special needs populations, as appropriate.

b. x Specify what constitutes "medically necessary services" consistent with the State's Medicaid State Plan program (i.e., the FFS program). Please list that specification or definition:

WAC 388-865-0150 defines **"Medical necessity"** or **"medically necessary"** - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation or, where appropriate, no treatment at all.

c. x Provide that the MCO/PHP furnishes the services in accordance with the specification or definition of "medically necessary services".

d. x Ensure implementation of written policies and procedures reflecting current standards of medical practice and qualifications of reviewers for processing requests for initial authorization of services or requests for continuation of services. Policies include:

1. x Specific time frames for responding to requests,

2. x Requirements regarding necessary information for authorization decisions,

3. x Provisions for consultation with the requesting provider when appropriate,

4. x Providing for expedited response for urgently needed services

5. x Clearly documented criteria for decisions on coverage and medical necessity that are based on reasonable medical evidence or a consensus of relevant medical professionals.

6. x Criteria for decision on coverage and medical necessity are updated regularly.

7. x Mechanisms to ensure consistent application of review criteria and compatible decisions.

8. x A process for clinical peer reviews of decisions to deny authorization of services on the grounds of medical appropriateness.

9. x Processes and procedures that ensure prompt written notification of the enrollee and provider when a decision is made to deny, limit, or discontinue authorization of services. (Note: current regulations require notice for a termination, reduction, or suspension of services which have already been authorized or when a claim for services is not acted upon with reasonable promptness. This check box should be marked when the State also requires notice when an enrollee's request for future services is denied, limited, or discontinued.) Notices include (check all that apply):

(a) x Criteria used in denying or limiting authorization

(b) x Information on how to request reconsideration of the decision.

(c) _____ Other (please describe):

10. x Mechanisms that allow providers to advocate on behalf of enrollees within the utilization management process.

11. x Mechanisms to detect both underutilization and over utilization of services.

12. _____ Other (please describe):

e.___ Other (please describe):

III. Selection and Retention of Providers

Previous Waiver Period

a.___ During the last waiver period, the selection and retention of providers were different than described in the waiver governing that period. The differences were:

b.__x__ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State monitored the process for selection and retention of providers checked in the previous waiver submittal [items C.III.a-h in the 1999 initial preprint; relevant sections of the 1995 preprint]. Also please provide results from the State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period.

MHD provides state licensure of community mental health centers and certification of involuntary treatment facilities. MHD receives the request for licensure and notifies the RSN. This notification is a courtesy as the RSN can not approve or deny licensure. The RSN (or county) must recommend a provider for certification. The first visit is to ensure the center is a viable entity financially, can meet the minimum WAC requirements, meets the requirements of ADA, has policies and procedures in place and has qualified staff. This visit usually results in a provisional licensure for one year. On the second visit (usually 9-10 months later) the team looks at clinical records and their QM process. Full licensure may be issued here or there may be corrective action. If there is corrective action the provider has 60-90 days to correct but all must be completed within one year from the date the provisional license was issued. If all corrective actions are not met the provider will be put on probationary status which requires new on-site visits. The RSN may contract with a provider on provisional licensure.

Upcoming Waiver Period

Please check any processes or procedures listed below that the State uses to ensure that each MCO/PHP implements a documented selection and retention process for its providers. For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires MCOs/PHPs to (please check all that apply):

a.__x__ Develop and implement a documented process for selection and retention of providers.

b.___ Have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source

verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

The RSNs use the state licensure/registration as their credentialling process. If during the course of the waiver there is a decision to move above that the state will convene stakeholder meeting(s) to develop statewide standards.

c.___ Have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1.___ Initial credentialing

2.___ Performance indicators, including those obtained through the following (check all that apply):

(a)__The quality assessment and performance improvement program

(b)__The utilization management system

(c)__The grievance system

(d)__Enrollee satisfaction surveys

(e)__Other MCO/PHP activities as specified by the State.

d.___ Use formal selection and retention criteria that do not discriminate against particular practitioners, such as those who serve high risk populations, or specialize in conditions that require costly treatment.

e.___ Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State _____

f.___Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

g. X Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.

The RSNs are required to notify the MHD if a Community Mental Health Center is providing

service below an acceptable level. MHD tracks critical incidents that occur in the community and also would be notified by the RSN if they were considering suspension or termination of a provider (CMHC) contract due to quality deficiencies. The MHD's licensing team would also then investigate this provider regarding licensing issues.

If a Community Mental Health Center suspends or terminates a therapist or Doctor reports are made in accordance with Title 18 and reported to the N.P.D.B.

h.___ Other (please describe):

IV. Delegation

Previous Waiver Period

a.___ During the last waiver period, delegation was different than described in the waiver governing that period. The differences were:

b. x [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

Part of the annual on-site monitoring ensures the participation and oversight of the RSN. The MHD holds the RSN legally responsible for all items in the contract and does not allow delegation of utilization and resource management to the provider of service. Language was added to both the WAC and the 01-03 contract to clarify the MHD's expectations regarding delegation. Monitoring of delegation authority will continue to be on-site and the MHD will review all subcontracts for delegation language.

**According to the new WAC, resource management may be delegated so long as the RSN identifies in the agreement with the mental health division any of these duties it has delegated to a subcontractor.

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State uses to ensure that contracting MCOs/PHPs oversee and are accountable for any delegated functions in Section C. Quality of Care and Services. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Where any functions are delegated by MCOs/PHPs, the State Medicaid Agency:

a. x Reviews and approves (check all that apply):

1. x All subcontracts ~~with individual providers or groups~~ *that cover services under the contract with the PHP.*

2.___ All model subcontracts and addendums

3.___ All subcontracted reimbursement rates

4.___ Other (please describe):

b. x Requires agreements to be in writing and to specify any delegated responsibilities.

c. x Requires agreements to specify reporting requirements.

d. x Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

e. x Monitors to ensure that MCOs/PHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

f. x Ensures that MCOs/PHPs monitor the performance of the entity on an ongoing basis.

g. x Monitors to ensures that MCOs/PHPs formally review the entity's performance at least annually.

h. x Ensures that MCOs/PHPs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.

i._____ Other (please explain):

V. Practice Guidelines

Previous Waiver Period

a._____ During the last waiver period, practice guidelines were different than described in the waiver governing that period. The differences were:

b.__ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in 1999 initial preprint; relevant sections of the 1995 preprint].

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs adopt and disseminate practice guidelines (please check all that apply). For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

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Guidelines:

a._____ Are based on reasonable medical evidence or a consensus of health care professionals in the particular field.

b._____ Consider the needs of the MCOs/PHPs enrollees.

c.__**__ *May be* developed in consultation with contracting *mental* health professionals.

There are few practice guidelines for the public mental health system in this state or on a national level. The RSNs have developed some guidelines based on the level of care a person needs, Individualized and Tailored Care guidelines, standards of care for consumers with co-occurring disorders, EPSDT, length of hospital stay, Intensive case management, and solution focus guidelines. However, these remain distinct in each RSN rather than accepted statewide. The Mental Health Advisory Committee has this last year established a forum for collecting and sharing best practices across the state.

There are planned meetings to develop practice guidelines with the RSNs, Community Mental Health Centers, consumers, parents and other family members. Once these are developed and approved they will be disseminated throughout the system.

d._____ Are reviewed and updated periodically.

e._____ Are disseminated to all providers, all enrollees (as appropriate) and individual enrollees upon request.

f._____ Are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.

g._____ Develop and implement policies and procedures for evaluating new medical technologies and new uses of existing technologies.

h._____ Other (please explain):

VI. Health Information Systems

Previous Waiver Period

a.___x__ During the last waiver period, health information systems of contracting MCOs/PHPs were different than described in the waiver governing that period. The differences were:

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The current waiver states "The State is aware that there is an intense need for common definitions across the State for data reporting. This will occur over the course of the waiver renewal at regular intervals when the data dictionary is opened for revisions. Over the course of the waiver renewal period, the State will be working to improve its data reports to reflect managed care concepts of access, utilization, cost and quality care.

Currently, the State is meeting routinely with the Information and Data Improvement Committee, which includes representatives from the RSNs, providers and the division. The issues this group deals with are substance improvements to the data dictionary, definition enhancements and general data management improvements to the overall system.

Additionally, the MHD is one of the sixteen MHSIP grants, which will last for three years. At this writing, MHD has been actively implementing the State Indicator Pilot Grant for the past six months. A work group has been meeting monthly to plan for the implementation of the Performance Indicators and begin examining the data elements for fit and reliability with the proposed measures. Meetings have been held with various groups of state and RSN staff for input and initial design of the performance indicators.

By the end of the grant, the mental health system will be better able to examine existing information, clarify definitions and data collection methods, develop alternative models, and continually improve performance through the effective use of feedback."

<u>During the course of the waiver:</u>

The State participated in the *16 state pilot indicator grant* sponsored by the Center for Mental Health Services to develop performance indicators for mental health based on the recommendations of the President's Task Force. The MHD was able to report on fourteen of the thirty-two indicators. This is consistent with the other states' experience as the grantees struggled to develop national definitions. Washington, like the other States, found similar issues to the *5 State feasibility study,* which was that definitions were not being applied evenly across the States. Washington along with other grantees has been working to standardize definitions and data for the indicators. Washington had, throughout this grant, a Performance Indicator Grant Workgroup (PIWG) and a Technical Review Group (TRG). The PIWG was made up of MHD staff, RSN staff, provider staff, consumers, family members and staff from both branches of the Washington Institute. The PIWG met monthly to discuss each proposed measure, developing a clear definition, examining the data base for fit and comparability with national reporting efforts. TRG was a broader stakeholder group that reviewed the indicator reports and provided feedback about interpretation and presentation of the information.

During the later part of the third year of the grant, the PIWG joined with the Information System Data and Evaluation Committee (ISDEC) to work together to standardized data definitions and to prepare for HIPAA. The MHD has recently revised its data dictionary in response to additional reporting needs identified by the grant and by ISDEC, these revisions take effect in October 2001. The data dictionary is in the final stages of completion at the time of this writing and will be forwarded to CMS, Region X upon its completion.

b.__x__ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

The State has access to standardized data within 60 days of the end of the reporting month. The quality of the standardized data received from the RSNs is tracked each quarter and error reports are returned to the RSNs quarterly for evaluation and corrections. The MIS section then keeps a notebook on all data quality issues to determine error trends and offer suggestions and technical assistance.

The State analysis of this data occurs in several ways. The Research Section of the MHD has constructed a Service Utilization database (SU) which is an individual level, unduplicated data base that allows analyses of the data across inpatient (including state psychiatric hospitals, community hospitals and E&T facilities) and outpatient activities.

The SU also allows data to be routinely gathered for analysis from the production side of the MHD-CIS system to be more easily available for matching and linking in a SAS–based data warehouse environment. This approach not only supports the research activities of the MHD, but provides unduplicated views and cuts of the data for answering policy questions.

Results of monitoring generally show that the RSNs submit data more timely and are working towards better data quality. The emphasis placed on the system by the PI grant and ISDEC is making all levels of the system more aware of data use.

c.__x__ Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and usability of data provided to the State by MCOs/PHPs.

The MHD's encounter data system is able to provide information on outpatient services within three (3) months of occurrence. This includes type of service, minutes of service, and demographic variables. Inpatient services are relatively complete within six (6) months, and final within eighteen (18) months. Recent changes to the data dictionary have standardized reporting requirements and data definitions. This should substantially improve the quality of the data being reported. Additional data quality reports are also being generated and disseminated to agencies to improve the quality of reporting.

The MHD has taken further steps which include the identification and definition of several data elements that can be used to produce outcome measures, and to further explore service utilization patterns, these include socio-economic status, diagnosis, and level of functioning. Beginning January 2002 agencies are now required to report these data elements at change or every three months.

Washington State – Integrated Community Mental Health Program
The system includes the Adhoc Reporting System that provides easy access to a set of commonly requested information as well as standard reports. Information from the reporting system is incorporated into management reports such as the monthly Fiscal Program Review and the Executive Management Report.

d._____ The State uses information collected from MCOs/PHPs as a tool to monitor and evaluate MCOs/PHPs (i.e. report cards). Please describe.

e._____ The State uses information collected from MCOs/PHPs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs/PHPs and/or providers). Please describe.

Upcoming Waiver Period
Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that MCOs/PHPs systems:

a. x Provide information on
1. x Utilization,
2. ____ Grievances,
3. ____ Disenrollment.
Grievance and disenrollment data is tracked manually and not through the IS system

b. x Collect data on enrollee and provider characteristics as specified by the State.

c. x Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe). The MCO/PHP is capable of (please check all that apply):

1. x [Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees

2. x [Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors
3. x Verifying the accuracy and timeliness of data

4. x Screening data for completeness, logic and consistency

5. x Collecting service information in standardized formats to the extent

feasible and appropriate

6.___ Other (please describe):

d. __x__ Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

1.__x__ *Mental* Health services (please specify frequency and provide a description of the data and/or content of the reports)

2.__**__ Outcomes of *mental* health care (please specify frequency and provide a description of the data and/or content of the reports)

Please see the information provided under i. in this section regarding performance indicators.

3._____ Encounter Data (please specify frequency and provide a description of the data and/or content of the reports)

4._____ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)

e. __x__ Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAP.

f. __x__ Ensure that information and data received from providers are accurate, timely and complete.

g. __x__ Allow the State agency to monitor the performance of MCOs/PHPs using systematic, ongoing collection and analysis of valid and reliable data.

h. __x__ Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

i. __x__ Other (please describe):

MHD has incorporated the following performance indicators into the 01-03 RSN contracts with plans to develop four more over the course of the contracts. The selection of the indicators was based on what data sources are currently available.

For the following measures, MHD will gather and report baseline data the first year and then during the second year, apply incentives and/or requests for management plans to improve

performance (e.g. where an RSN is below standard or the mean of RSNs):

1. Penetration rates for services by race/ethnicity, age, gender, and Medicaid eligibility.
2. Utilization rate for services by race/ethnicity, age, gender, and priority population
3. Recipient perception of access
4. Recipient perception of quality/appropriateness of services
5. Recipient perception of active participation in decision making regarding treatment
6. Percentage of service recipients age 16 and above who are employed
7. Average annual cost per recipient served
8. Average annual cost per unit of service (cost per hour for community services)
9. Percent of revenues spent on direct services
10. Percent of recipients who were homeless in the last 12 months by age and priority population
11. Percentage of children who live in "family-like" settings
12. Percentage of children and adolescents receiving services in natural settings ("out of clinician office")

The following measures will be under development during the 01-03 contract period and are included in the contract. MHD will gather and report data throughout the contract period and work to refine the indicators:

13. Percentage of recipient who are maintained in the community without a psychiatric hospitalization during the last 12 months.
14. Percentage of recipients who receive services by both MHD and DASA in the previous 12 months.
15. Percentage of consumers who access physical healthcare.
16. Percentage of service recipients living in stable environments.

It is important to note here that these indicators will be for all persons served (by age and ethnicity) however, in most indicators it is possible to separate Medicaid from the non-Medicaid population served. The framework for developing indicators may be found in attachment

Additionally, the MHD will be building a database to acquire relevant information in collaboration with Office of Research and Data Analysis on the services received by American Indians and Alaska Natives to report on a regular basis to IPAC and AIHC.

VII. Quality Assessment and Performance Improvement (QAPI)

Previous Waiver Period

a.___ During the last waiver period, the State's Quality Assessment and Performance Improvement (QAPI) program was different than described in the waiver governing that period. The differences were:

b.__x__ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in 1999 initial preprint; relevant sections in the 1995 preprint]. Please break down monitoring results by subpopulations if available.

Data charts in Attachment AIIId2bii.

c._____ The State or its MCOs/PHPs conducted performance improvement projects that achieve, through on-going measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two-year period.

Upcoming Waiver Period- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs maintain an adequate QAPI. For items a through u, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that MCOs/PHPs (check all that apply and note in narratives if the State intends to break down the results by subpopulation):

a.__x__ Have an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPI. The State has standards which include (check all that apply):

1.__X__ A policy making body which oversees the QAPI

2.__X__ A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

3.__X__ Active participation by providers and consumers

4.__X__ Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

5.___ Other (please describe):

b._____ Measure their performance, using standard measures established or adopted by the State Medicaid agency, and reports their performance to the applicable agency. Please list or attach the standard measures currently required.

c._____ Achieve required minimum performance levels, as established by the State Medicaid agency on standardized quality measures. Please list or attach the

standardized quality measures established by the State Medicaid agency.

d._____ Conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction.

Please list the projects currently planned for each year of the waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

e.__X__ Correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

f.__X__ Are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

g._____ Are allowed to conduct multi-year projects that meet the improvement standards as described in QISMC or that are specified in a project work plan developed in consultation with the State Medicaid agency.

h.__X__ Select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient's mental health care and member services.

i.__X__ Select and prioritize topics for projects to achieve the greatest practical benefit for enrollees.

j.__X__ Select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

k.__X__ Provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

l.__X__ Assess and measure the organization's performance for each selected topic using one or more quality indicators.

m.__X__ Base the assessment of the organization's performance on systematic, ongoing collection and analysis of valid and reliable data.

n.__**__ Establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year

after a desired level of performance is achieved.

o._____ Use a sampling methodology that ensures that results are accurate and reflective of the MCOs/PHPs enrolled Medicaid population.

p._____ Meet previously-determined standards to define results that show significant demonstrable improvement in performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project identified.

q.__x__ Use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

r.__x__ Ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

s.__x__ Administer their QAPI through clear and appropriate administrative arrangements.

t.__x__ Formally evaluate, at least annually, the effectiveness of the QAPI strategy, and make necessary changes.

u.____ Other (please describe):

Attachment C.1a

Quality Management Template

The Quality Management Plan will comply with WAC 388-865-0225(4), -0280; 42 CFR 434 part 4,5,6; 42 CFR 434 (a-e) (Waiver), or any successors.

Quality Management and Improvement

A. Program Structure

1. Describe the Contractor's Quality Management Plan's structure and contents, including:.
   a) how the governing body oversees the QI program.
   b) how often the plan and overall process is evaluated
   c) describe the role, structure and function of the QI committee, to include how often it meets. If you have multiple QI/QA committees or processes, please provide a flow diagram to show how these committees and activities intersect.
   d) outline your current annual QI workplan or schedule, to include:
      i) a list of your stakeholders, to include allied systems as well as formal/informal community systems and how they link into the overall workplan
      ii) the role of enrollees and families in quality management activities
      iii) projects and activities for the current year
      iv) planned monitoring of previously identified issues and how they are tracked over time
      v) how follow-up actions are developed and communicated back through the system
      vi) how the workplan will be evaluated and by whom.
   e) indicate if resources are available and adequate to meet the scope of the program.
   f) if resources are insufficient to meet the scope of the plan, describe what efforts will be in place to increase resources to ensure full implementation of the QM plan.

B. Program Operation

1. The Quality Management process is expected to be fully operational. It should meet the following standards:
   a. establish and describe how QI committee recommendations and policy decisions are reviewed and executed, including the evaluation of quality improvement activities, instituting needed actions, and ensuring appropriate follow-up. Identify designated person(s) with the authority/responsibility to oversee implementation and management of the QM plan.
   b. ensure current minutes are maintained which are signed and dated and reflect all QI committee decisions and actions.
   c. describe how providers and stakeholders have clear opportunity to be active participants in the QI program.
   d. describe how the Contractor shall ensure that measures of enrollee voice and satisfaction, including information provided by independent entities, are incorporated into the region's overall Quality Management program.
   e. describe how the Contractor monitors expected levels of quality services and whether the needs of enrollees are met and uses the information to increase the quality of services and shape best practices toward the deal level of services and support.
   f. describe a QA/QI communication plan that assures that individuals bringing issues to the QA/QI committee for action or review get appropriate feedback, and that the system or stakeholders they represent are also informed of decisions which impact them.

C. Program Implementation

1. Describe how the Contractor will demonstrate the implementation of the Quality Management (QM) Plan.

2. Collection of information about the regional system will include:

a) administrative structures and processes including relevant financial and cost information and service utilization data
b) System Performance Indicators and enrollee outcome measures
c) clinical care and services (e.g., inpatient, outpatient, crisis, resource management, etc.)
d) demonstration of an effective process for analyzing and interpreting information, making recommendations, and developing strategies for action
e) demonstration of an effective process for implementing improvement activities and evaluating results
f) the Contractor shall collect, analyze and display sufficient information to assure and demonstrate the capacity to manage resources and deliver appropriate quality and intensity of services including, but not limited to, access to services, resource management, crisis system and services. Information collection strategies shall include, but not be limited to, analysis of care provided to at least a 20% sample (or 500 total if smaller) representative sample of enrollees recipients on an annual basis.

D. Contracting for Services

Describe how the Contractor's provider network, including both individuals and agencies, has substantial involvement and demonstrate unified efforts in implementing quality improvement activities that are consistent and congruent with the overarching Contractor quality improvement strategies.

E. Availability of Providers

The Contractor must ensure that its network is sufficient in numbers, mix of practitioners, and geographic distribution of providers in order to meet: 1) an appropriate range of services, including preventive care (e.g., EPSDT screening), case management and specialty services; 2) anticipated numbers of enrollees; 3) access and travel standards.

Describe how the Contractor: a) collects and analyzes data to measure its performance against the standards it has established; b) implements interventions to improve its performance and measures the effect of the interventions

F. Accessibility of Services

The Contractor must ensure that all covered services are both available and accessible in order to meet contractual standards.

Describe how the Contractor: a) collects and analyzes data to measure its performance against these standards; b) identifies opportunities to improve and demonstrates how to address them; c) implements interventions to improve performance and measures the effect of the interventions.

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G. Enrollee Satisfaction

1. Describe the Contractor's process to implement mechanisms to measure and improve the level of enrollee satisfaction, including but not limited to describing the process to ensure:

   a) Ombuds and QRTs are functionally independent in the performance of their duties and and are expected to improve the level of enrollee satisfaction. (see definition at the end of this template)
   b) Ombuds/QRT findings and reports, recommendations, and findings are considered in good faith by the PHP
   c) Ombuds/QRT reports, recommendations and findings are analyzed and appropriate decisions are made regarding follow-up activities and interventions
   d) Ombuds/QRT and Advisory Board recommendations are addressed and incorporated into ongoing operations including but not limited to contracting activities and other management decisions.
   e) Processes are in place to resolve disputes with Ombuds/Quality Review Team (QRT) members. For disputes not resolved with those procedures, there will be a dispute resolution process in place to deal with system-level matters.
   f) Effective policies and procedures will be in place which ensure that Advisory Board, Ombuds and Quality Review Team members are free from retaliation (or the perception of retaliation) in the performance of their duties.

2. Describe how the Contractor: a) analyzes the data from the activities listed above and identifies opportunities to improve; b) implements interventions to improve performance and measures the effectiveness of those interventions.

H. Continuity and Coordination of Care

Describe how the Contractor ensures the continuity and coordination of services enrollees receive and how it monitors these variables within and across network agencies, formal and informal supports, and allied systems. Include how this information is available to the agencies and systems being monitored, and how the data is evaluated annually.

I. Clinical and Performance Measurement Activities

1. Describe how the Contractor uses data collection, measurement and analysis to track clinical issues relevant to the population served. At a minimum, the Contractor will monitor system capacity, the intensity of services, the supports being provided to the population, and outcomes being achieved through these services. This includes:

   a. quality of clinical care as well as the intensity and appropriateness of clinical care and related services and supports;
   b. analysis of clinical care and related services and support
   c. analysis of linkages to other systems to ensure enrollees' needs are addressed and services are not duplicated.
   d. guidelines will include a focus on enrollee mental health outcomes and the appropriate use of clinical guidelines and quality indicators

2. Describe the Contractors Peer Review process:
   a. how the process identifies clinical care issues, to include the intensity and appropriateness of clinical care as well as related services and supports. This should include both the coordination and continuity of care.
   b. How the identified issues and their outcomes are analyzed, monitored and or resolved
   c. How continuous quality improvement of clinical and performance measures is evaluated, and how findings are used to improve clinical care as well as the

coordination and continuity of care.

3. Describe how the Contractor adopts or establishes quantitative measures to assess performance and to identify and prioritize areas of improvement for one or more clinical issues. Identify how:

a) the measures used to assess performance are objective and quantifiable.

b) the affected population is identified, and appropriate samples are drawn from this enrollee base in a valid and reliable manner.

c) the Contractor analyzes the data collected for each assessment measure.

d) appropriate personnel, to include providers, evaluate the analyzed data in order to identify barriers to improvement related to clinical practice and/or administrative aspects of the delivery system.

e) the interpretation of the data will be made available to providers, and their feedback will be incorporated into any subsequent reports.

J. Effectiveness of the Quality Improvement Program

Describe how the Contractor annually evaluates the overall effectiveness of the QI program and demonstrates improvements in the quality of care and the quality of service to its stakeholders. The Contractor will submit an annual written evaluation report based on the analysis of its overall operations to the MHD to comply with Section 1.4.8 of the Reports and Deliverables section of the 01-03 Agreement.

K. Delegation of Quality Improvement Activity

Describe any activities that are delegated. If the Contractor delegates any QI activities, there is evidence of oversight of the delegated activity. At a minimum, there is a mutually agreed-upon document describing:

1. responsibilities of the Contractor and the delegated entity
2. activities that are delegated
3. frequency of reporting to the Contractor
4. process by which the Contractor evaluates the performance of the delegated entity
5. remedies, including revocation of the delegation, available to the Contractor if the delegated entity does not fulfill its obligations.

Utilization/Resource Management

1. Describe the Contractor's Utilization Management Structure, including:

a) a written description outlines both program structure and accountability

b) the scope of the program and the processes and information sources used to make determinations of benefit coverage and level of care.

c) how the UM program is evaluated and approved annually by the Contractor or designee or the QI Committee.

2. Describe the Contractor's Resource Management Structure, including:

a) How the Contractor will ensure there are policies and practices in place to deal with situations in which there is:

i) unanticipated need for the availability of such providers with particular types of experience, or

ii) unanticipated limitation of the availability of such providers including the identification of network mental health PCPs who are not accepting new Medicaid consumers

3. Describe how utilization decisions are made using written criteria based on local levels and standards of care and medical necessity. The Contractor will establish specific procedures for applying the criteria in an appropriate manner. Ensure that: a) the procedures for applying criteria are based on the needs of individual enrollees and characteristics of the local delivery system. These criteria are available to providers upon request; b) at least annually the Contractor evaluates the consistency with which the health care professionals involved in utilization review apply the criteria in decision making.

4. Describe how the contractor ensures that it provides coordination for pharmaceutical management and coordination with physical health care based on the need of individual enrollees.

5. Describe how the Contractor facilitates the delivery of appropriate care and has mechanisms in place to detect and correct potential under- and over-utilization. This should include how the Contractor: a) monitors data to detect potential under- and over-utilization; b) routinely analyzes all data collected to detect under-and over-utilization; c) implements appropriate interventions whenever such utilization patterns are identified; d) measures whether the interventions have been effective and implements strategies to achieve appropriate utilization.

Enrollee Rights and Responsibilities

Describe how the contractor will demonstrate: 1) all complaint and grievance requirements are met; 2) incorporation of the Contractor's MHD-approved Complaint and Grievance Plan into the overall QM process.

Definitions:

Functional independence is the ability to conduct the performance of duties free from interference and control, limitation, retaliation or penalty by any official of the contractor or sub-contractor.

In assessing whether an Ombuds person or a Quality Review Team is independent in structure, function and appearance, it is important to consider whether Ombuds or QRT has been provided:

1. sufficient funds to accomplish the task;
2. access to pertinent information and people
3. time and space adequate to conduct necessary business
4. timely opportunities to report interference, control, penalties and retaliation
5. support and consultation from the appointing entity.

Marketing Template

General Requirements

Each Contractor shall develop a marketing plan, in accordance with Washington Administrative Code (WAC) 388-865-0330 or its successor. The primary intent behind the provisions of this WAC are to assure enrollees are notified of the existence and availability of the Contractor; to advise them of their enrollee rights; to promote access to enrollees who are of Limited English Proficiency; and to promote stigma reduction activities.

Contractors are requested to use WAC 388-865-0330 as the basic format for establishment of their marketing plans. They are also requested to use information about use of services to focus on groups that may not be accessing services at rates comparable to their percentages of the general population and to target efforts to reach them.

Specific Requirements

Each Contractor shall have policies and procedures in place that will govern their marketing activities. The policies and procedures will be in compliance with WAC 388-865-0330. They will also use service delivery information to target marketing to enrollees who are under-served or under-represented in the service population.

The elements of the plan shall include the following:

- There are methods to advise enrollees of their rights and responsibilities.
- Enrollees are advised of the availability of Ombuds services, of their right to express dissatisfaction with services at the provider, Contractor and state administrative hearing level and of their rights to request to be disenrolled.
- The plan will demonstrate Contractor methods to establish and maintain cross-system linkages.
- The plan establishes, implements, and tests methods to provide access to diverse populations, including enrollees who are of Limited English Proficiency.
- The Contractor can demonstrate that various public media are used to publicize the marketing plan.
- Stigma reduction is incorporated into the plan as a significant element.
- Enrollees are involved in the efforts.
- Sub-contractor participation is incorporated into the plan.
- There are established methods by which the plan is evaluated and revised on a regular basis.

- The method to evaluate the marketing plan incorporates a review of service data that includes enrollment and use of crisis, inpatient, community support services and residential services. The plan will be structured to target marketing efforts to under-served groups.
- Materials that publicize (including brochures, news articles, television and radio announcements or other means of publicizing) services will include information about toll-free numbers to access services, describe services and hours of operations, and will assure effectiveness in reaching enrollees who are visually or auditorily impaired or who are LEP.
- Materials are publicized in at least the languages that are most commonly used within the service area.
- Information about the availability and how to access Ombuds services and local advocacy organizations is posted and is generally made available.
- Materials that publicize services, rights and associated information are distributed through allied providers.
- Brochures include: Range of options for treatment; range of options for supports; information about the scope of available benefits; service locations; enrollee responsibilities; non-covered services; how to access services for out-of area emergencies, including any limitations; what constitutes unauthorized service; what constitutes services that are not covered.
- Brochures will also include information about how to express dissatisfaction at the provider, Contractor and state administrative (fair) hearing levels.

The revised Marketing plan will be submitted to MHD for written approval within 90 days of the execution of the 01-03 Agreement.

Grievance System Template

Generai Requirements

Each Contractor must have a system that includes a grievance process, an appeal process and access to the State's fair hearing system. The Contractor will establish performance-based policies and procedures to implement its grievance system.

The Contractor must obtain written approval from the MHD before implementing the policies and procedures that govern its grievance system. These policies and procedures must be submitted for approval no later than 90 days from the execution of the 01-03 Agreement. The 99-01 policies and procedures will remain in place until such time as the 01-03 replacements have been approved.

The Contractor will be expected to demonstrate:

- there is a process by which enrollees who receive or apply for services may express dissatisfaction about any matter at the provider level and at the Contractor level
- there is a process by which the enrollee may appeal dissatisfactions when "actions" are involved or for other reasons, in accordance with WAC 388-865-0255, at the state administrative (fair) hearing level.
- there is a process consistent with WAC 388-865-0255 (Consumer Grievance Process) and WAC 388-865-0340 (Disenrollment), by which the enrollee may pursue appeals or grievances at the state administrative hearings level without first pursuing them at the Contractor level, except in the case of requests for disenrollment. In cases of disenrollment there is a process by which the enrollee must first utilize the Contractor's complaint and grievance procedures.
- Contractor's grievance and appeal processes are based on written policies and procedures
- policies apply to the Contractor and sub-contractors.
- the governing body of the Contractor has approved and is responsible for effective operation of the grievance system.
- there are provisions in the grievance system policies and procedures for the governing body or its designees review and dispose of grievances and appeals of actions.
- the grievance system ensures that no punitive action nor retaliation is threatened nor taken against an enrollee, provider or any individual or group involved in pursuit of resolution of any dissatisfaction at the provider, Contractor or state administrative hearing level.

- there are provisions for extension of timeframes requested by the enrollee, his or her representative or a provider acting on behalf of the enrollee with the enrollee's written consent.
- the Contractor can demonstrate that enrollee requests for the Contractor to address a grievance at the Contractor level will be reviewed according to local policies and procedures and a decision made within 30 days of receipt of the request
-

SPECIFIC REQUIREMENTS

Notice

- the grievance system requires providers to give notice of service determinations and options to contest those determinations and other

Handling Of Grievances and Appeals

- the method by which the Contractor's grievance system will handle grievances and appeals assures adequate staffing to handle grievances and appeals and assures that enrollees have reasonable assistance in pursuing grievances and appeals

Resolution and Notification

- the Contractor has established local requirements for disposing of grievances, resolving appeals and providing notice to enrollees and their representatives expeditiously
- the Contractor assures that the time frames for standard disposition of grievances shall be 30 days or less, in accordance with current state requirements
- there are no provisions for extensions of the timeframes to dispose of a grievance based on a denial of a request to expedite a resolution of an appeal.
- the Contractor demonstrates that written notice is given to enrollees who have filed a grievance or an appeal of an action at the Contractor level, and the notices contain an explanation of the disposition of the grievance or the results of the resolution of the appeal of the action
- the Contractor informs the enrollee how to seek further state review and how to request it when there is dissatisfaction with disposition of grievances
- grievance policies and procedures assure that the Contractor and its sub-contractors will participate in the State Administrative (Fair) Hearings process in cooperation with the Mental Health Division and abide by those decisions.

Information about the Grievance System

- Contractor provides information about the right to a hearing, the method for obtaining a hearing and the rules that govern hearings to enrollees, providers and sub-contractors.

Record Keeping and Reporting

- records of all grievances and appeals are kept for a least a three year period.
- Contractors analyze the records on an annual basis or more frequently, and submit to the MHD a summary (Exhibit N of the 01-03 Agreement) that includes: a) the number and nature of grievances and appeals; b) the timeframes within which they were disposed or resolved; c) the nature of the decisions.

Continuation of Benefits while Appeal and Fair Hearing Are Pending

- the Contractor continues benefits to enrollees while appeals and state administrative (fair) hearings processes are in progress
- enrollees are notified that they may be responsible for payment of costs of services in the event that an Administrative Hearing upholds the Contractor's action
- enrollees are notified that the Contractor may have to pay for benefits provided during an appeal if the Administrative hearing upholds the appellant's grievance
-

Implementation of Reverse Appeal Resolutions

- the Contractor authorizes or provides the disputed services promptly and expeditiously when a state fair hearing reverses a decision to deny, limited or delay services that were not furnished while the appeal was pending

Monitoring of the Grievance System

- the grievance and appeals records serve as the basis for monitoring by the Contractor
- the Contractor conducts an in-depth review and takes corrective action if review of the grievance system indicates a need to change the system.

Definitions

Action means:

a. the denial or limited authorization of a requested service, including the type or level of service;
b. the reduction, suspension or termination of a previously authorized service;
c. the denial, in whole or in part, of payment for a service;
d. the failure to furnish or arrange for a service or provide payment for a service in a timely manner;

Administrative Hearing means

a hearing conducted through the auspices of the state Office of Administrative hearings in accordance with WAC 388-02. The term "fair hearing" is synonymous with administrative hearing.

Appeal means:

This term applies specifically to an expression of dissatisfaction that involves any authorization or denial of services, which will generally be pursued at the Contractor level and which may be pursued at the RSN/PHP or state administrative hearing level.

Grievance means:

an expression of dissatisfaction about any matter other than an action, which is defined above. The term, "grievance", is also used to refer to the overall system that includes grievances and appeals handled at the Contractor level and access to the State Fair Hearing Process. This term applies to any expression of dissatisfaction that may be presented for resolution at the provider level, at the Contractor level and at the state administrative hearings level.

Attachment C.1a1

MENTAL HEALTH DIVISION
QUALITY MANAGEMENT PLAN

I. Introduction

A. Overview of the Plan

The Mental Health Division's Quality Management Plan is designed to be a template for statewide system management and oversight of mental health services in Washington. As such it is expected to meet the standards set by the Health Care Financing Administration (HCFA) and the Washington Administrative Code (WAC), and to support and enhance the missions of all 14 Washington Regic al Support Networks (RSN) And, perhaps most importantly, this Plan is meant to highlight the importance of the active voice of consumers in planning their care, choosing their goals, and integrating community resources into their treatment plans.

B. Mission of Mental Health Division

The Mental Health Division administers a public mental health system that promotes recovery and safety.
We value the strength and participation of consumers and their and their families.
We value the cultural and diverse qualities of each consumer.
We value our partners in delivering quality, cost effective and individualized services.

C. Guiding Principles

The Mental Health Division will insure consumer access to high quality and medically necessary mental health care in accordance with federal and state requirements. The Mental Health Division is committed to a statewide delivery system which is characterized by:

1. community based care which is close to family and social support systems and is consumer driven
2. development with input and advice from the public, consumers and other stakeholders
3. a focus on serving consumers who are the most seriously and persistently mentally ill or seriously emotionally disturbed
4. Use of the least restrictive alternative to achieve the desired outcome
5. Applicable programs and services available and culturally competent for ethnic minority consumers.

The Mental Health Division is committed to statewide services that:

1. are provided with respect and dignity
2. are accessible and available 24 hours a day, 7 days a week
3. meet individual consumer and family needs
4. are based on consumer, family, provider and community strengths
5. are culturally sensitive, age appropriate, linguistically appropriate, and are fully accessible to people with disabilities or other special needs
6. are community based and normalizing, provided in facility or non-facility settings, in the consumer's environment and in the community
7. assure continuity of care and integration with allied systems and physical health care providers
8. are effective and acceptable to the consumer and the purchaser.

D. Scope of the Quality Management Plan

Quality Management is an all-encompassing system and process that incorporates quality assurance and quality improvement activities. Quality Assurance refers to the compliance to minimum standards as defined by WAC and reasonable expected levels of performance. Quality Improvement is the sum of activities that identify need for improvement and change in program design and service delivery through

the gathering and analysis of data. The oversight of these functions is charged to the Mental Health Division's Quality Council. The Quality Council has a collateral role, as well as an integrative role, with the Division's Quality Improvement Steering Committee, various advisory committees, System Improvement Group (SIG), RSN quality management oversight committees, Western and Eastern State Hospitals, and Child Study and Treatment Center. The Quality Council is charged with integrating data collected and reported by these stakeholders into its work of identifying areas that need to be improved. This integration process has two purposes for this Council: to assure minimum compliance on standards and to contribute to the information base of quality improvement work.

II. Mental Health Division Quality Management Plan

A. Mental Health Division Quality Structure

Attached is a flow diagram, to include allied system as well as formal/informal community systems and how they link into the overall work plan. This diagram also indicates how information flows within the quality management system. Aspects of the communication flow between committees and stake holders which need to be formalized in a communication plan:

1. Getting issues from stakeholders into the quality program structure
2. Management of issues within the quality program committee structure
3. Getting Issues released from the quality program committee structure and back to stakeholders

B. MHD Management Team/Quality Council

1. The Quality Council oversees the QM (Quality Assurance and Quality Improvement) program.
2. The QM Plan is evaluated annually by the Quality Council. Quality Improvement processes are evaluated quarterly by the Quality Improvement Steering Committee and are rolled up to the Quality Council.
3. The Quality Council reviews Steering Committee recommendations and determines how policy decisions are reviewed and executed, including evaluation of quality improvement activities, instituting needed actions, and insuring appropriate follow-up
4. Identifies designated person(s) with the authority responsibility to oversee implementation and management of the QM plan.
5. The Council will complete minutes in a timely manner. They will reflect all Steering Committee recommendations and the Council's decisions and actions
6. The Council will determine how stakeholders will have clear opportunity to be active participants in the QI process. Enrollee voice and satisfaction , including information provided by independent entities, will be incorporated into the Division's overall Quality Management program and safe-guarded by the Quality Council.
7. The Quality Council monitors expected levels of quality services and whether the needs of enrollees are met, and how this information is used to increase the quality of services and share best practices toward the ideal level of services and support.
8. The Council will meet to determine projects and activities for the current year as well as [illegible] work plan. This work plan will also address how the Council will:
    a) develop a process for the planned monitoring of previously identified [illegible], how they are tracked over time.
    b) Develop a methodology for determining follow-up actions and how they communicated back through the system. The methodology will include how stakeholders are informed of decisions that impact them.
    c) develop a process for how the Division's QMP will be evaluated and by whom.
9. The Council will determine if quality management improvement resources are available and adequate to meet the scope of the plan. If resources are inadequate to meet the scope of the plan, they will describe what efforts are in place to increase resources to insure full implementation of the QMP.

C. Management and Staff Accountability for QA and QI

1. Collection of data and information about the statewide system will include:
   a. administrative structures and processes including relevant financial and cost information and service utilization data
   b. system Performance Indicators and enrollee outcome measures
   c. clinical care and services (e.g., inpatient, outpatient, crisis, resource management)
   d. demonstration of an effective process for analyzing and interpreting information, making recommendations, and developing strategies for action
   e. demonstration of an effective process for implementing improvement activities and evaluating results
2. Development of a methodology for analyzing contract deliverable reports from RSNs and trending the information for statewide reports. Feedback information for each RSN will include benchmarks for:
   a. Provider availability (appropriateness range of services, responsiveness to anticipated number of enrollees, access and travel standards)
   b. Accessibility of services (appointment standards, waiting list issues)
   c. Enrollee satisfaction
   d. Continuity and coordination of care
   e. Clinical and performance measurement activities (system capacity, intensity of services and supports being provided, outcomes of these actions)
   f. Usage of clinical guidelines and quality indicators
   g. Innovative programs and best practices

3. Communication within the CQI Process.

The communication flow between committees and stake holders is a critical one

4. Getting issues from stakeholders into the quality program structure
5. Management of issues within the quality program committee structure
6. Getting Issues released from the quality program committee structure and back to stakeholders

D. Mental Health Division Quality Improvement Steering Committee (QISC)

1. The QISC ensures that the goals and principles of the Mental Health Division are carried out and incorporated into all activities, programs and services funded by MHD.
2. The QISC coordinates various Division quality functions, to include information flow between consumers and stakeholders and the Quality Council.
3. QISC members will work together to change and refine MHD activities and actions regarding provider and system oversight to insure that services funded and/or administered by MHD are performing as intended and are making the changes necessary to constantly improve.
4. QISC functions include the following:
   a. Oversee implementation, updating and revision of Quality Management plan, activities and performance concerns, indicators, measures, targets and thresholds.
   b. Determination and implementation of data to be collected and analyzed for QMP purposes
   c. Develop and implement a process for determining when additional monitoring activities have to occur (e.g. thresholds)
   d. Analysis of data and information received to give a complete picture of the performance of the subject under review
   e. Determination of types of reviews and other monitoring activities, purposes of reviews, as well as the extent of review. Where reviews have already taken place (e.g., licensing and certification), determine type of summary information to be given to QISC.
   f. Determination and development of tools and forms to be utilized

g. Coordination of timing and scheduling of monitoring activities (especially on site reviews of providers)
h. Dissemination of information regarding status of follow-up and closure on reviews and monitoring activities.
i. Determination and implementation of actions necessary to assure provider and system compliance with rules, contract requirements, amd quality management and improvement activities.
j. Identification, development and delivery of technical assistance and/or training needed by providers and the system as a whole in order to improve.
k. Preparation of reports and recommendations to decision-makers when indicated.

APPENDIX 1 – PURPOSE, STRUCTURE AND WORKPLAN OF QUALITY IMPROVEMENT STEERING COMMITTEE

The Quality Improvement Steering Committee (QISC):

1. Oversees and manages the activities described in the *Responsibilities/Functions* section of this plan
2. Ensures that the goals and principles of the Mental Health Division are carried out and incorporated into all activities, programs and services funded by MHD.
3. Coordinates various Division quality functions, to include information flow between consumers and stakeholders and the Quality Council.
4. QISC members work together to change and refine MHD activities and actions regarding provider and system oversight to insure that services funded and/or administered by MHD are performing as intended and are making the changes necessary to constantly improve.
5. QISC functions include the following:
    a. Overseeing implementation, updating and revision of Quality Management plan, activities and performance concerns, indicators, measures, targets and thresholds.
    b. Determination and implementation of data to be collected and analyzed for QMP purposes
    c. Development and implementation of a process for determining when additional monitoring activities have to occur (e.g. thresholds)
    d. Analysis of data and information received to give a complete picture of the performance of the subject under review
    e. Determination of types of reviews and other monitoring activities, purposes of reviews, as well as the extent of review. Where reviews have already taken place (e.g., licensing and certification), determine type of summary information to be given to QISC.
    f. Determination and development of tools and forms to be utilized
    g. Coordination of timing and scheduling of monitoring activities (especially on site reviews of providers)
    h. Dissemination of information regarding status of follow-up and closure on reviews and monitoring activities.
    i. Coordination of communication about review results.
    j. Outline process for the planned monitoring of previously identified issues and how they are tracked over time

6. QISC members will include a representative from:
    a. the Mental Health Advisory Board
    b. the RSN leadership group
    c. WA State provider group
    d. Systems Improvement Group (SIG)
    e. MHD HQ Quality Improvement Group
    f. Hospital Quality Council
7. QISC will be co-chaired. Co-Chairman 'A' will have the following role:
    a. schedule and convene meeting
    b. manage logistics for meetings
    c. assure minutes are taken and distributed
    d. manage agenda setting for meetings and activities
    e. identify consultant assistance when needed
    f. Chair meetings every other quarter to begin with _____

    Co-chairman 'B' will have the following role:
    a. maintain membership roster and attendance records
    b. assure participation and updating of members not present
    c. identify and assure preparation of materials needed by the group
    d. maintain record of materials used/developed

e. maintain and distribute decision/recommendation forms (to include completed ones)
f. chair meetings every other quarter beginning ___ _____

BOTH co-chairs will:

k. approve draft minutes
l. be a liaison to and from the Quality Council
m. brief management staff on actions taken and recommendations for action by management staff
n. make decisions and resolve conflicts when the QISC is unable to do so.

7. Suggested projects and activities for the current year:
   a. Identify members of the QISC
   b. Convene organizing meetings of the QISC
   c. Determine the need for any QISC subcommittees.
   d. Meet together to refine and understand structure, goals, charge and function/responsibilities of QISC
   e. Develop and disseminate a process for bringing forward and responding to quality management/improvement issues and staff's quality management/improvement concerns.
   f. Develop a process for how follow-up actions are developed and communicated back through the system
   g. Guide finalization of the draft QMP Plan
   h. Oversee implementation of initial QMP activities, including the delegation of activities to QISC members
   i. Set meeting schedule for the remainder of the calendar year.
   j. Inventory on-site review reports and discuss system issues and trends.
   k. With QA&I team, discuss the review process and what changes are indicated for the next review cycle.
   l. With QA&I team, discuss retooling process and issues still to be resolved.
   m. With QA&I team, discuss scheduling for next review period (to begin in October 2001)
   n. Identify and begin methods for sharing information regarding monitoring activity results
   o. Identify data sources and standards for performance indicators, measures and targets.
   p. Determine tools necessary to implement monitoring of performance indicators and targets.
   q. Review and update MHD QMP
   r. Develop annual QI Steering Committee Work Plan, including the identification of priorities, action steps to be taken, and timeliness.

Attachment C. VI.i

Mental Health Division

Framework for Defining and Displaying System-Wide Mental Health Performance Indicators

The data in this report was produced through the "data warehouse" using SAS. As these Performance Indicators are reviewed and sanctioned by stakeholders, Regional Support Networks (RSNs), and Mental Health Division Management, they will be placed into "Production". It is anticipated that the data in these graphs have an error margin of plus or minus 5 percentage points as compared to the "Production" data produced by the Division.

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System Level Performance Indicators: A Working Definition

Performance Indicators provide information on how well a system is doing. The federal *General Accounting Office* defines Performance Measurement as: "The on-going monitoring and reporting of system-wide accomplishments, particularly progress toward pre-established goals...conducted by the program or agency management (GAO, 1988)." The Washington State Department of Social and Health Services utilizes the Mental Health Statistics Improvement Program (MHSIP) paradigm to understand the domains of mental health information:

- **WHO** (gets) receives services
- **WHAT** (from) types of services are delivered
- **WHOM** (at what) staffing patterns
- **COST** fiscal viability

Outcome Measures provide specific client-level information on the results of services:

- **OUTCOMES:** What happens to the individual as a **RESULT** of the mental health care they receive?

The goal of the ***Performance Indicator Project*** is to develop Indicators and Outcome Measures to determine how well the mental health system assures access, quality and cost effectiveness and to report these indicators out to stakeholders on a regular basis.

Performance Indicators:

- Provide information on the number of clients accessing services, how services are delivered, which outcomes or goals are achieved, and how dollars are spent.
- Reflect agreed upon values and goals.
- Are clear, reliable (results same each time) and valid (measure used is measuring what is says).
- Help system managers and system payers understand trends in service delivery systems and change across time.
- Provide feedback on system accountability and have the potential to improve quality and services.

Performance Indicators address the following **large areas of concern** (which have been, in part, defined by Federal funding sources):

- Access to Services
- Outcomes – improvement in client's level of functioning
- Quality /Appropriateness of Services
- Cost

Persons or Groups interested in Performance Indicators may include:

- Mental Health Division staff
- Consumers
- Family members
- Advocates
- Regional Support Networks (RSNs)
- Legislators
- Hospital and Community providers
- Federal Funding sources/oversight (HCFA, JCAHC)
- Other Federal programs (NASMHPD, MHSIP, CMHS)
- Other interested parties

Data Discussion:

To define and develop System-wide Performance Indicators, three things must be considered:

- available or collectable information (what data do we have?)
- the process of describing and interpreting the information (what does the data mean?)
- and the application and use of the finished indicator (how will the information be used?)

Performance Indicators for the Washington State mental health system will come from a combination of the following three data systems for mental health services and surveys:

- the Mental Health Division Consumer Information System (MHD-CIS)
- the State Psychiatric Hospital data base (HIIS) Health Integrated Information System)
- the Medicaid Management Information System payment data base (MMIS)
- the Mental Health Statistics Improvement Project (MHSIP), Youth Services Survey (YSS), and the Youth Services Survey for Families (YSS-F)

The data that describes the number and type of services received may be collected in one or more of the major three databases. Service data provides a picture of each client's mental health service use in a given time period (a month, or a calendar year).

The indicators display the RSNs in the order of their population, from the smallest to the largest.

DEFINITION OF ACCESS:

Access refers to the degree to which services are quickly and readily delivered to a consumer. It may include the responsiveness of the Washington State Mental Health system to individual and cultural needs, the amount and types of services received, and the client's perception of the availability of services.

Access I. ***Penetration Rates***
The proportion of persons receiving mental health services in Washington State.

Access II. ***Clients by Age***
The proportion of persons receiving mental health services by age (0-17,18-59, 60+)

Access III. ***Clients by Mental Illness Indicator***
The number and proportion of persons receiving mental health services by mental illness indicator (Chronic, Serious, Other, and Acute).

Outpatient Access IV. ***Average Outpatient Hours***
The average hours of services received by clients in Outpatient Services during the Fiscal Year.

Inpatient Access V. ***Community Psychiatric Inpatient and Emergency and Treatment (E&T) Service Utilization***
The percent of clients using Community Psychiatric Inpatient and E&T Services by RSN and Statewide during the Fiscal Year.

Inpatient Access VI. ***Community Psychiatric Inpatient and E&T Days***
The average number of Community Psychiatric Inpatient and E&T days per Client by RSN and Statewide during the Fiscal Year.

Inpatient Access VII. ***Inpatient Days by Ethnicity and Proportion of Ethnic Group using Inpatient Services***
The average number of Inpatient days per Fiscal Year by Ethnicity (African American, Asian, Caucasian, Hispanic, Native American, Other Ethnicity) in All Hospital Types.

Access VIII. ***Consumer Perception of Access***
A base measure taken from the Statewide Sampling Based Outcome Data (SbOS).

ANALYSES AND DISPLAY OF INDICATORS:

All indicators, when analyzed and displayed, can be broken down and displayed by various sub-populations. The potential includes, but is not limited to, displays by RSN, Medicaid population, age, ethnicity, gender or other service or descriptive variables.

C.VI-1

ACCESS I. Penetration Rates: The proportion of persons receiving mental health services in Washington State by RSN and Statewide.

Rationale for Use: Penetration Rates provide information on the number of persons who receive one or more mental health services relative to the Medicaid and/or general populations. Penetration rates also provide information on whether the system is responsive to various client populations (i.e., age, ethnicity, gender). It also allows comparisons to other state mental health data to help understand access across state mental health systems.

A. Operational Measures: The proportion of persons in the general population who receive publicly funded mental health services.

Formula:

$$\frac{\text{\# of unduplicated persons who receive mental health services during the Fiscal Year}}{\text{\# of persons in the general population (estimated census)}}$$

Discussion: The penetration rates by RSN and Statewide show the total population of each RSN and the State. In this measure, for the statewide count each person in only counted once, even if he/she uses more than one service, uses both Inpatient and Outpatient Services or is served by multiple RSNs. At the RSN level, a person is counted once if using more than one service or is served by Inpatient and Outpatient Services. If a person is served by multiple RSNs, the person is counted in each RSN where service was received.

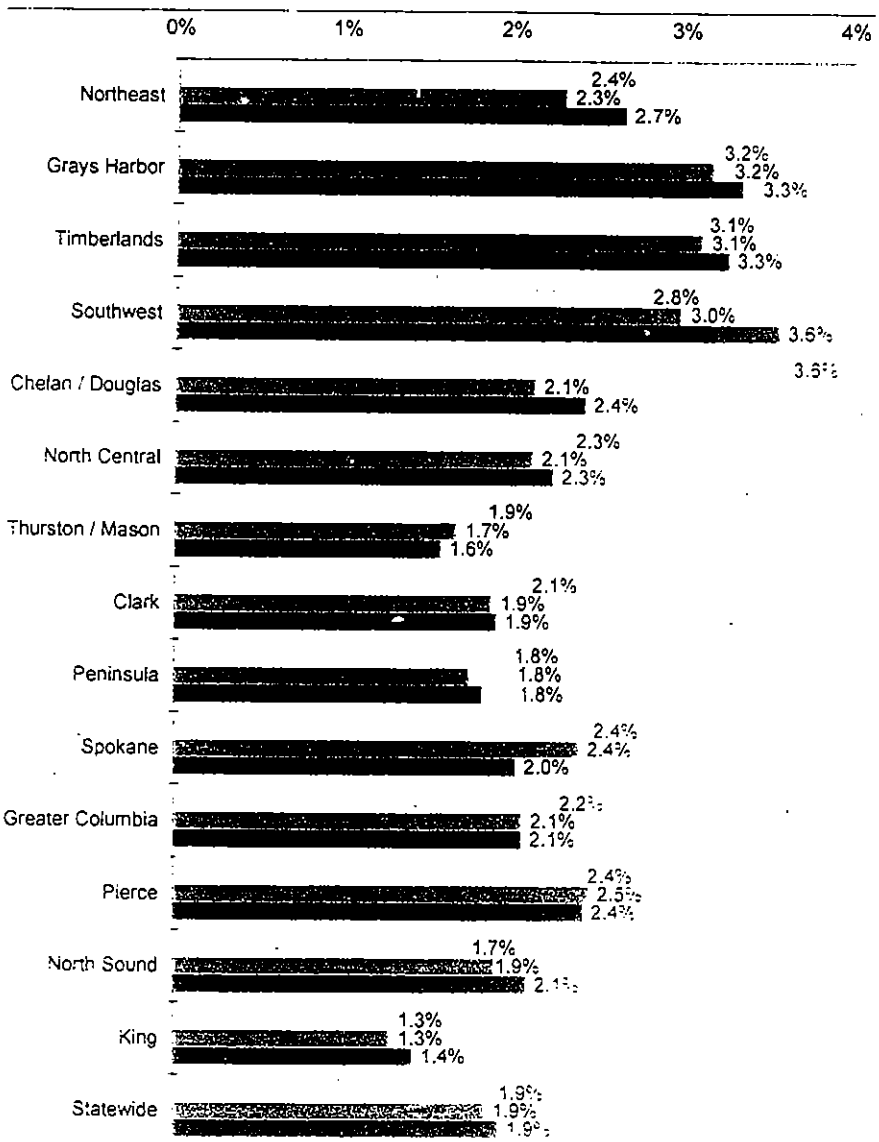
Data Notes:

- The State Total is unduplicated clients across all RSNs (i.e., each person is only counted once in the state).
- The RSN count shows the number of unduplicated clients within each RSN (i.e., one person is counted in <u>each</u> RSN in which they received services).
- Target Period includes July 1, 1997 through June 30, 2000.
- Counts do not include services to youth who are only served in CLIP.
- Counts are of people, not admissions or episodes.
- Data Source is Service Utilization data base (specific data set = testbig.sd2).
- Medicare data is not consistently reported.
- King RSN does not report Crisis Units. Clients who only receive Crisis Services are not counted in the number of clients served.
- Results calculated on data extracted March 2001

Penetration Rate (Served / RSN Pop) All Outpatient Service Modalities / Calc. 3/2001 SAS / DRAFT

Access I

	FY98			FY99			FY00		
	Served	Pop	Rate	Served	Pop	Rate	Served	Pop	Rate
Northeast	1,580	65,899	2.4%	1,487	64,412	2.3%	1,654	62,191	2.7%
Grays Harbor	2,168	68,102	3.2%	2,142	67,446	3.2%	2,253	67,260	3.3%
Timberlands	2,906	93,748	3.1%	2,887	92,644	3.1%	2,979	91,119	3.3%
Southwest	2,571	92,549	2.8%	2,801	93,543	3.0%	3,369	94,286	3.6%
Chelan / Douglas	3,375	93,502	3.6%	2,022	94,271	2.1%	2,323	95,232	2.4%
North Central	2,874	123,097	2.3%	2,610	122,174	2.1%	2,715	120,553	2.3%
Thurston / Mason	4,622	246,749	1.9%	4,214	250,579	1.7%	4,064	255,742	1.6%
Clark	6,711	322,401	2.1%	6,233	329,123	1.9%	6,345	330,383	1.9%
Peninsula	5,659	322,149	1.8%	5,740	325,151	1.8%	6,092	331,076	1.8%
Spokane	10,047	410,398	2.4%	9,958	413,306	2.4%	8,546	418,526	2.0%
Greater Columbia	12,849	572,002	2.2%	11,971	576,277	2.1%	12,019	579,612	2.1%
Pierce	16,430	680,552	2.4%	17,189	695,191	2.5%	17,296	710,296	2.4%
North Sound	15,553	898,909	1.7%	17,577	916,680	1.9%	19,543	930,751	2.1%
King	21,493	1,656,002	1.3%	21,825	1,681,740	1.3%	24,428	1,706,362	1.4%
Statewide	**106,727**	**5,646,055**	**1.9%**	**106,208**	**5,722,532**	**1.9%**	**112,024**	**5,793,385**	**1.9%**



B. Operational Measure: The proportion of persons by age group who receive publicly funded mental health services.

Formula:

$$\frac{\text{\# of unduplicated persons by age group who receive mental health services during the Fiscal Year}}{\text{\# of persons in the general population (estimated census)}}$$

Discussion: The penetration rates by RSN and Statewide show the general population by age group for each RSN and the State. In this measure, each person is only counted once, even if he/she uses more than one service or uses both Inpatient and Outpatient Services. When a person is served by multiple RSNs, the person is counted once for each RSN in which services were received.

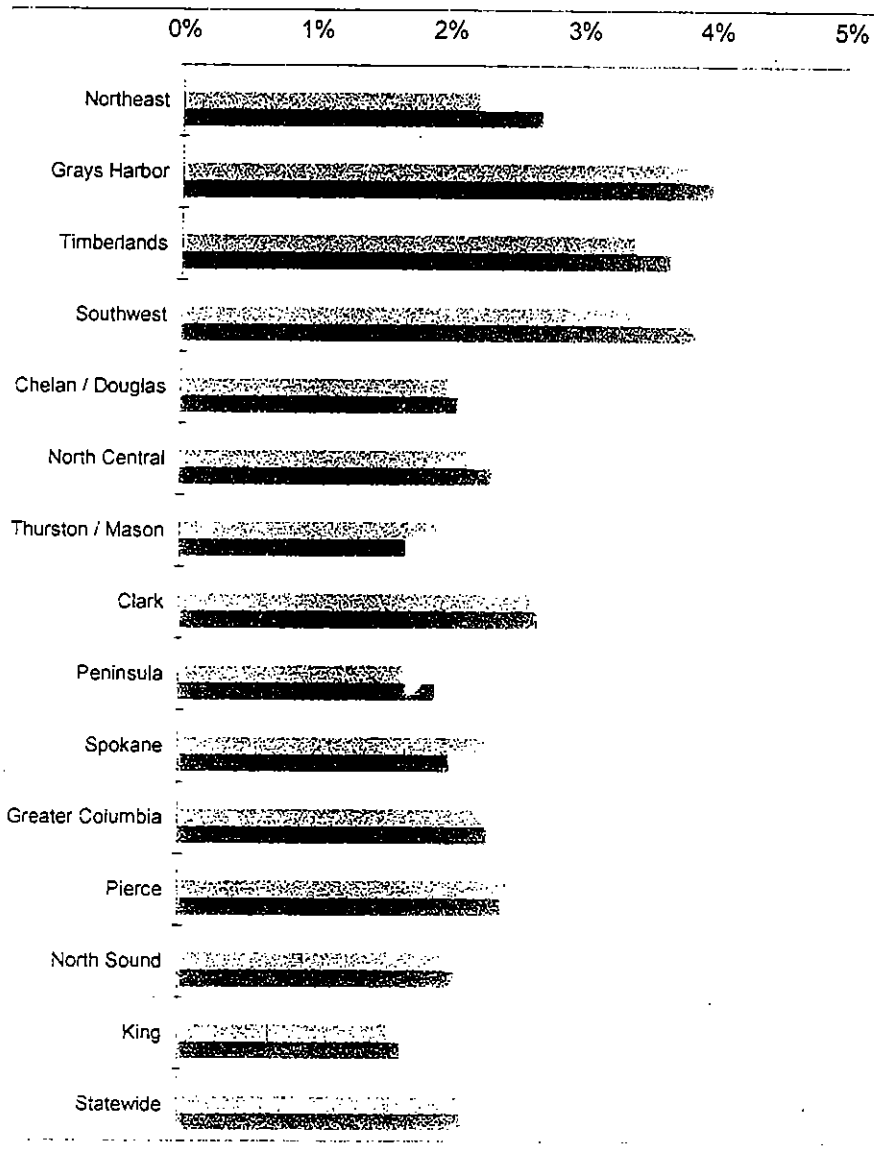
Data Notes:

- Age is calculated as of July 1 each fiscal year.
- The State Total is unduplicated clients across all RSNs (i.e., each person is only counted once in the state).
- The RSN count shows the number of unduplicated clients within each RSN (i.e., one person is counted in <u>each</u> RSN in which they received services).
- Target Period includes July 1, 1997 through June 30, 2000.
- Counts do not include services to youth who are only served in CLIP.
- Counts are of people, not admissions or episodes.
- Data Source is Service Utilization data base (specific data set = testbig.sd2).
- Medicare data is not consistently reported.
- King RSN does not report Crisis Units. Clients who only receive Crisis Services are not counted in the number of clients served.
- Results calculated on data extracted March 2001

Penetration Rate (Served / RSN Pop) Outpatients Youth 0-17 Yrs. / Calc. 3/2001 SAS / DRAFT

Access I

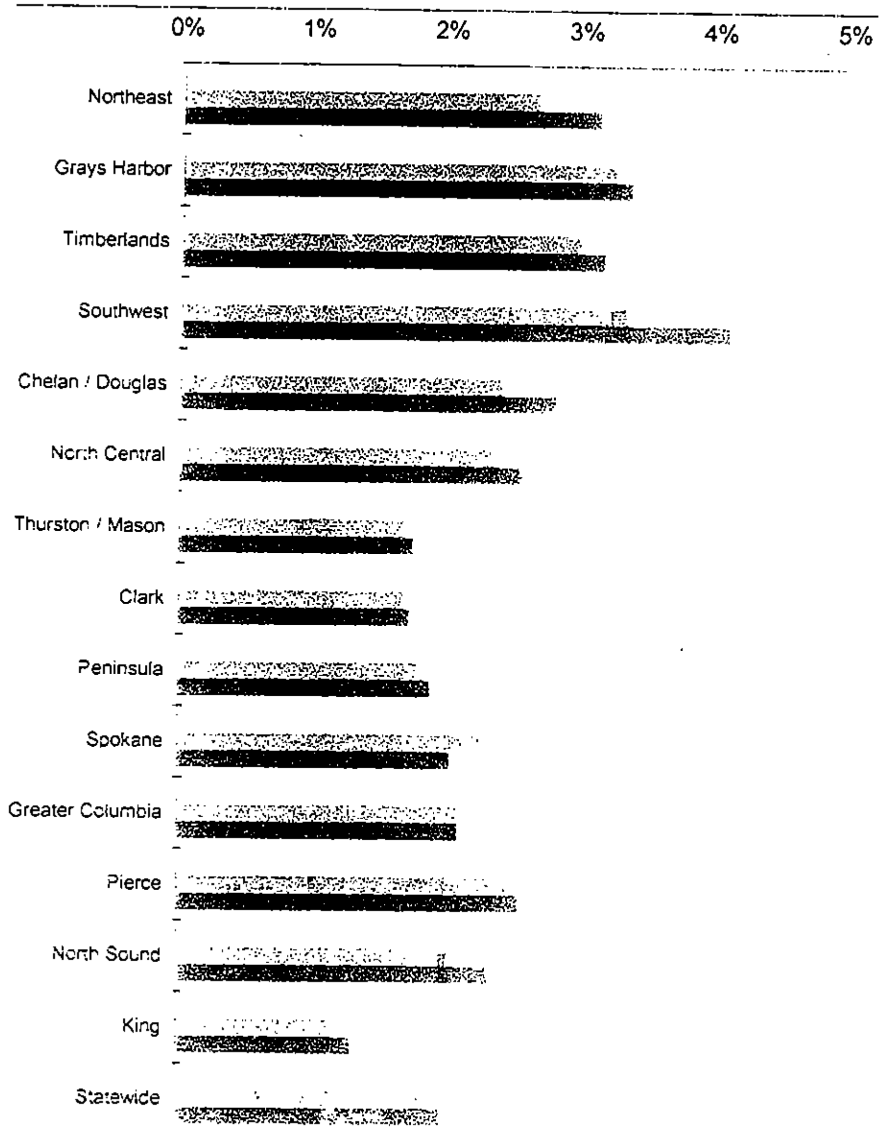
	FY98 Youth			FY99 Youth					
	Served	Pop	Rate	Served	Pop	Rate			
Northeast	427	19,275	2.2%	420	18,777	2.2%	488	18,109	2.7%
Grays Harbor	680	18,622	3.7%	699	18,286	3.8%	720	18,076	4.0%
Timberlands	846	25,495	3.3%	858	25,093	3.4%	904	24,636	3.7%
Southwest	738	25,223	2.9%	874	25,296	3.5%	977	25,250	3.9%
Chelan / Douglas	556	26,493	2.1%	535	26,559	2.0%	558	26,767	2.1%
North Central	827	38,148	2.2%	831	37,648	2.2%	867	36,975	2.3%
Thurston / Mason	1,440	65,955	2.2%	1,303	66,361	2.0%	1,153	67,169	1.7%
Clark	2,778	92,953	3.0%	2,538	94,043	2.7%	2,526	93,511	2.7%
Peninsula	1,564	86,955	1.8%	1,492	87,128	1.7%	1,705	88,063	1.9%
Spokane	2,629	109,604	2.4%	2,538	109,570	2.3%	2,247	110,011	2.0%
Greater Columbia	3,835	166,505	2.3%	3,866	166,436	2.3%	3,871	166,143	2.3%
Pierce	4,764	188,419	2.5%	4,771	190,911	2.5%	4,697	193,334	2.4%
North Sound	4,856	248,301	2.0%	5,044	251,076	2.0%	5,263	252,633	2.1%
King	6,401	404,948	1.6%	6,551	409,898	1.6%	7,009	415,224	1.7%
Statewide	**32,341**	**1,516,893**	**2.1%**	32,320	1,527,079	2.1%			2.1%



Penetration Rate (Served / RSN Pop) Outpatients Adults 18-59 Yrs. / Calc. 3/2001 SAS / **DRAFT**

Access I

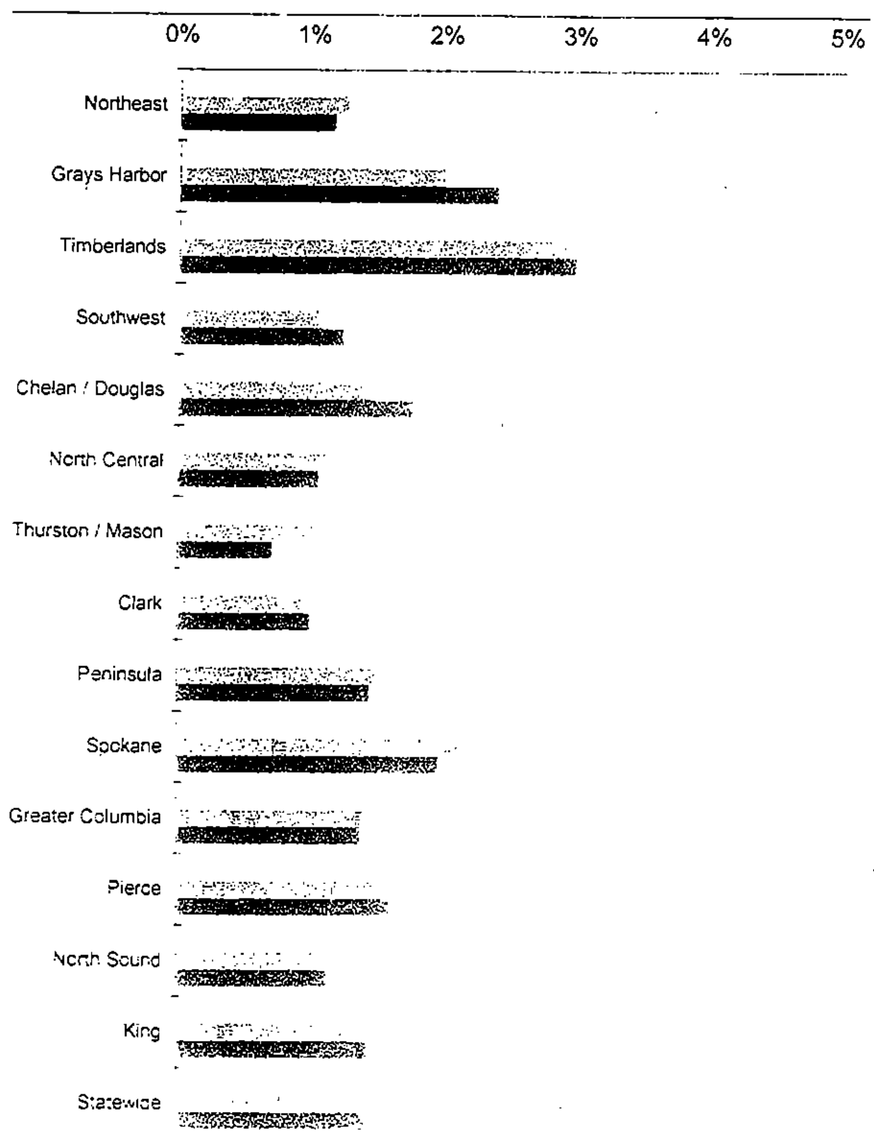
	FY98 Adults			**FY99 Adults**			[illegible]		
	Served	***Pop***	***Rate***	***Served***	***Pop***	***Rate***			
Northeast	935	35,344	2.6%	923	34,429	2.7%	1,035	33,134	3.1%
Grays Harbor	1,101	36,429	3.0%	1,182	36,250	3.3%	1,226	36,444	3.4%
Timberlands	1,409	48,795	2.9%	1,455	48,265	3.0%	1,509	47,582	3.2%
Southwest	1,504	51,346	2.9%	1,747	52,071	3.4%	2,167	52,681	4.1%
Chelan / Douglas	1,068	50,442	2.1%	1,244	51,018	2.4%	1,465	51,677	2.8%
North Central	1,553	64,869	2.4%	1,539	64,555	2.4%	1,636	63,906	2.6%
Thurston / Mason	2,540	141,256	1.8%	2,465	143,894	1.7%	2,611	147,149	1.8%
Clark	3,423	186,701	1.8%	3,273	191,2[illegible]3	1.7%	3,367	192,371	1.8%
Peninsula	3,261	180,953	1.8%	3,409	183,112	1.9%	3,563	186,764	1.9%
Spokane	5,658	235,215	2.4%	5,524	237,784	2.3%	4,974	241,837	2.1%
Greater Columbia	6,844	320,198	2.1%	6,890	324,074	2.1%	6,955	327,734	2.1%
Pierce	9,688	397,680	2.4%	10,564	407,619	2.6%	10,742	417,766	2.6%
North Sound	8,893	519,962	1.7%	11,084	531,705	2.1%	12,680	540,701	2.3%
King	11,855	1,018,018	1.2%	12,138	1,035,230	1.2%	13,934	1,050,648	1.3%
Statewide	**59,732**	**3,287,202**	**1.8%**	**63,437**	**3,343,230**	**1.9%**	[illegible]	[illegible]	**2.0%**



Penetration Rate *(Served / RSN Pop)* *Outpatients Elders 60+ Yrs.* / Calc. 3/2001 SAS / **DRAFT**

Access I

	FY98 Elders			**FY99 Elders**			[illegible]		
	Served	***Pop***	***Rate***	***Served***	***Pop***	***Rate***			
Northeast	157	11,280	1.4%	144	11,207	1.3%	129	10,948	1.2%
Grays Harbor	325	13,051	2.5%	259	12,910	2.0%	306	12,740	2.4%
Timberlands	556	19,460	2.9%	574	19,286	3.0%	566	18,902	3.0%
Southwest	227	15,981	1.4%	175	16,176	1.1%	204	16,356	1.2%
Chelan / Douglas	224	16,567	1.4%	243	16,694	1.5%	298	16,788	1.8%
North Central	231	20,081	1.2%	240	19,972	1.2%	211	19,673	1.1%
Thurston / Mason	332	39,538	0.8%	445	40,324	1.1%	299	41,425	0.7%
Clark	427	42,747	1.0%	421	43,852	1.0%	448	44,501	1.0%
Peninsula	769	54,242	1.4%	837	54,912	1.5%	823	56,250	1.5%
Spokane	1,505	65,580	2.3%	1,895	65,953	2.9%	1,322	66,678	2.0%
Greater Columbia	1,123	85,300	1.3%	1,209	85,768	1.4%	1,193	85,735	1.4%
Pierce	1,452	94,453	1.5%	1,503	96,661	1.6%	1,602	99,196	1.6%
North Sound	1,499	130,647	1.1%	1,441	133,899	1.1%	1,564	137,418	1.1%
King	2,996	233,037	1.3%	3,133	236,612	1.3%	3,481	240,490	1.4%
Statewide	**11,823**	**841,961**	**1.4%**	**12,519**	**854,223**	**1.5%**	[illegible]	[illegible]	**1.4%**



C. Operational Measure: The proportion of persons in the Medicaid population who receive publicly funded mental health services.

Formula:

$$\frac{\text{\# of unduplicated Medicaid eligible persons who receive mental health services during the Fiscal Year}}{\text{\# of persons in the Medicaid population in the same Fiscal Year}}$$

Discussion: The penetration rates by RSN and Statewide show the Medicaid eligible population of each RSN and the State. In this measure, each Medicaid eligible person is counted only once, even if he/she uses more than one service. When a person is served by multiple RSNs, the person is counted once for each RSN in which services were received.

Data Notes:

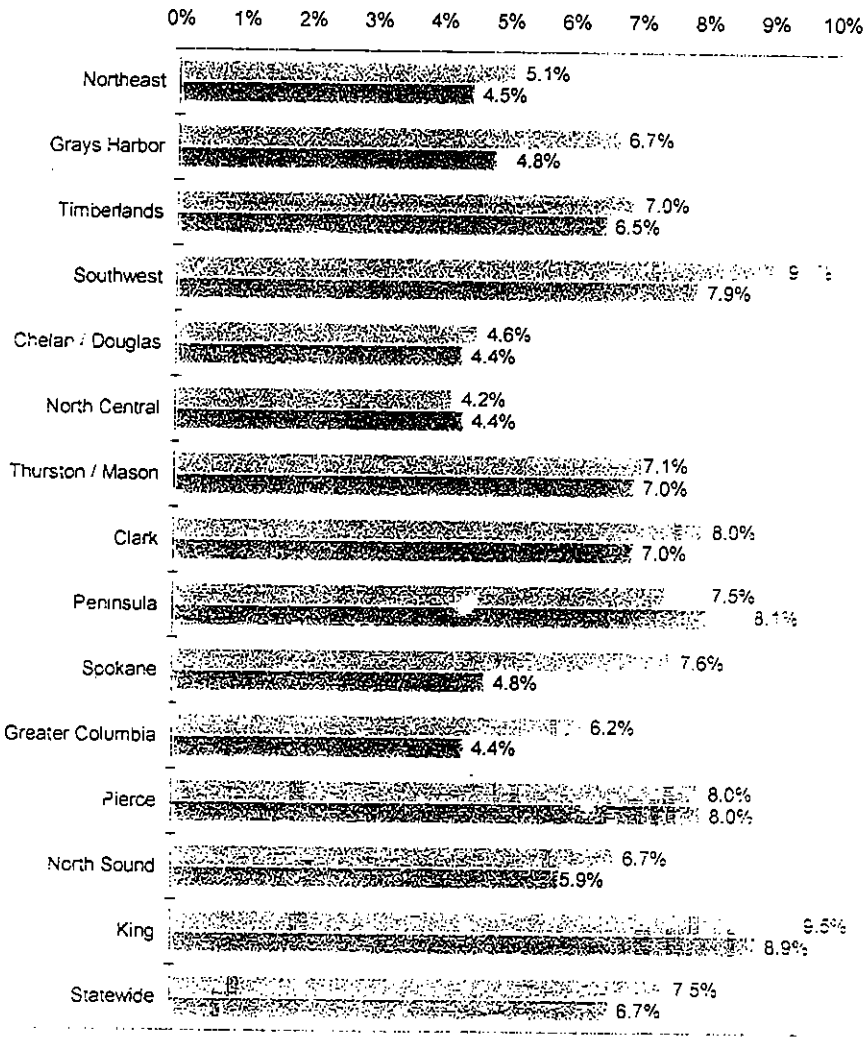
- The State Total is unduplicated clients across all RSNs (i.e., each person is only counted once in the state).
- The RSN count shows the number of unduplicated clients within each RSN (i.e., one person is counted in <u>each</u> RSN in which they received services).
- Target Period includes July 1, 1997 through June 30, 2000.
- Counts do not include services to youth who are only served in CLIP.
- Counts are of people, not admissions or episodes.
- Data Source is Service Utilization data base (specific data set = testbig.sd2).
- Medicare data is not consistently reported.
- King RSN does not report Crisis Units. Clients who only receive Crisis Services are not counted in the number of clients served.
- Results calculated on data extracted March 2001

TXIX Penetration Rate (Served / RSN Eligible) Outpatient Services

/ Calc. 3/2001 SAS / **DRAFT**

Access I

	Calendar Year 1999					
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Northeast	838	16,379	5.1%	807	18,026	4.5%
Grays Harbor	1,125	16,796	6.7%	852	17,676	4.8%
Timberlands	1,390	19,996	7.0%	1,453	22,315	6.5%
Southwest	1,787	19,593	9.1%	1,674	21,177	7.9%
Chelan / Douglas	845	18,358	4.6%	880	20,134	4.4%
North Central	1,468	34,660	4.2%	1,667	38,000	4.4%
Thurston / Mason	2,747	38,509	7.1%	2,942	42,078	7.0%
Clark	4,296	53,449	8.0%	4,213	60,297	7.0%
Peninsula	3,440	45,935	7.5%	4,010	49,480	8.1%
Spokane	5,879	77,669	7.6%	4,027	84,696	4.8%
Greater Columbia	8,337	133,744	6.2%	6,427	144,948	4.4%
Pierce	9,174	114,572	8.0%	9,987	124,399	8.0%
North Sound	8,119	120,571	6.7%	7,887	133,636	5.9%
King	18,793	198,809	9.5%	19,363	218,231	8.9%
Statewide	68,234	969,040	7.5%			

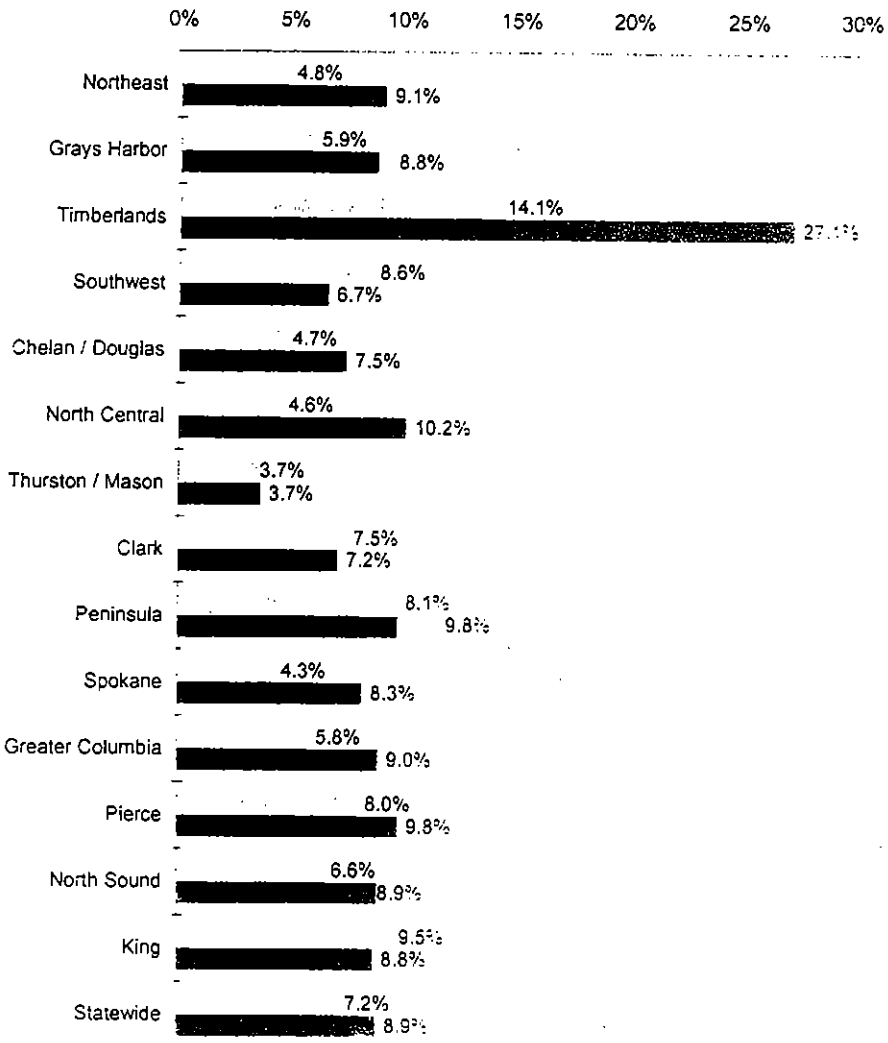


TXIX Penetration (T19 Served / T19 Elig) (T19 Hrs / Tot Hrs) Outpatient Services

/ Calc. 3/2001 SAS / **DRAFT**

Access I

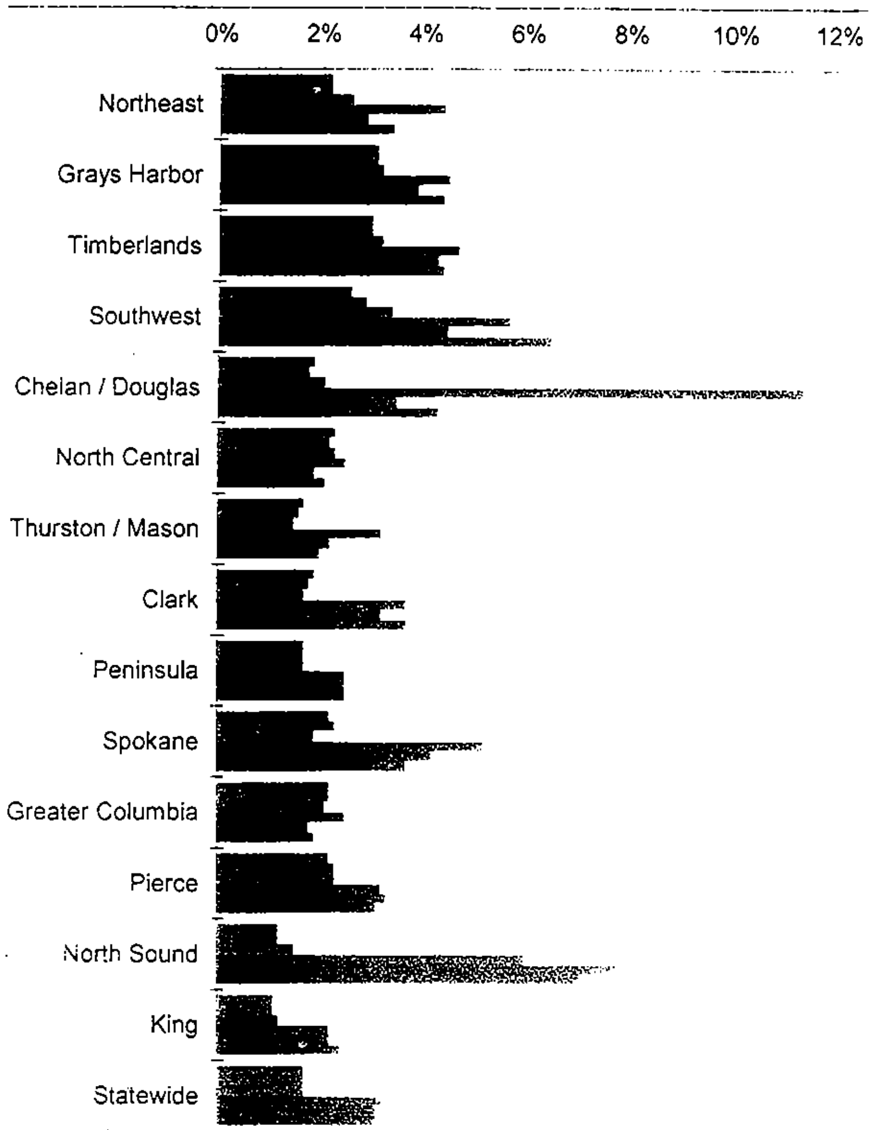
	TXIX Served FY 2000			TXIX Hours FY 2000		
	TXIX Served	Eligible	Rate	TXIX Hrs	Tot Hrs	Rate
Northeast	784	16,379	4.8%	3,738	40,960	9.1%
Grays Harbor	996	16,796	5.9%	3,712	41,959	8.8%
Timberlands	2,829	9,996	14.1%	7,820	28,803	27.1%
Southwest	1,683	19,593	8.6%	2,712	40,546	6.7%
Chelan / Douglas	866	18,358	4.7%	3,784	50,256	7.5%
North Central	1,585	34,660	4.6%	4,623	45,437	10.2%
Thurston / Mason	1,428	38,509	3.7%	3,106	83,687	3.7%
Clark	3,997	53,449	7.5%	17,736	247,085	7.2%
Peninsula	3,737	45,935	8.1%	16,635	169,321	9.8%
Spokane	3,337	77,669	4.3%	15,799	191,099	8.3%
Greater Columbia	7,822	133,744	5.8%	23,850	265,775	9.0%
Pierce	9,214	114,572	8.0%	41,349	419,937	9.8%
North Sound	7,898	120,571	6.6%	20,295	226,943	8.9%
King	18,956	198,809	9.5%	63,250	721,015	8.8%
Statewide	**65,132**	**909,040**	**7.2%**	**228,408**	**2,572,823**	**8.9%**



Penetration Rate *(Served / RSN Pop) Outpatients by Caucasian/Non-Caucasian* / Calc. 3/2001 SAS / **DRAFT**

Access I

	Proportion of Caucasian Pop			Proportion of Non-Caucasian Pop		
	FY98	*FY99*	*FY00*	*FY98*	*FY99*	*FY00*
Northeast	2.2%	2.2%	2.6%	4.4%	2.9%	3.4%
Grays Harbor	3.1%	3.1%	3.2%	4.5%	3.9%	4.4%
Timberlands	3.0%	3.0%	3.2%	4.7%	4.3%	4.4%
Southwest	2.6%	2.9%	3.4%	5.7%	4.5%	6.5%
Chelan / Douglas	1.9%	1.8%	2.1%	11.4%	3.5%	4.3%
North Central	2.3%	2.2%	2.3%	2.5%	1.9%	2.1%
Thurston / Mason	1.7%	1.6%	1.5%	3.2%	2.2%	2.0%
Clark	1.9%	1.8%	1.7%	3.7%	3.2%	3.7%
Peninsula	1.7%	1.7%	1.7%	2.5%	2.5%	2.5%
Spokane	2.2%	2.3%	1.9%	5.2%	4.2%	3.7%
Greater Columbia	2.2%	2.2%	2.1%	2.5%	1.8%	1.9%
Pierce	2.2%	2.3%	2.3%	3.2%	3.3%	3.1%
North Sound	1.2%	1.2%	1.5%	6.0%	7.8%	7.1%
King	1.1%	1.1%	1.2%	2.2%	2.2%	2.4%
Statewide	**1.7%**	**1.7%**	**1.7%**	**3.2%**	**3.1%**	**3.1%**



ACCESS II. Number and Proportion of Mental Health Clients by Age by RSN and Statewide

Rationale for Use: The proportion of mental health clients by age provides information on the number and percent of clients served by age. The three age groups are: children ages 0-17, adults ages 18-59, and elder ages 60+.

This indicator helps to illustrate the accessibility of mental health services across these age groups. Of the total clients served (unduplicated count,) the number and proportion of children, adults, and elders receiving services provides information on the number of clients who receive at least one mental health service.

Operational Measure: The number and proportion of unique publicly funded mental health clients who are children, adults, and elders.

Formula:

$$\frac{\text{number of unduplicated mental health clients by age \{children; adult; elder\}}}{\text{number of unduplicated persons who received mental health services during the Fiscal Year}}$$

Discussion: Age is calculated on July 1 of the fiscal year. For example for FY 1998, the count of children shows the number who were 0-17 years of age on July 1, 1998. The total number of persons in this graph are slightly lower than other graphs because Date of Birth is not available for all clients. This data only shows those individuals for whom a birth date is reported.

Data Notes:

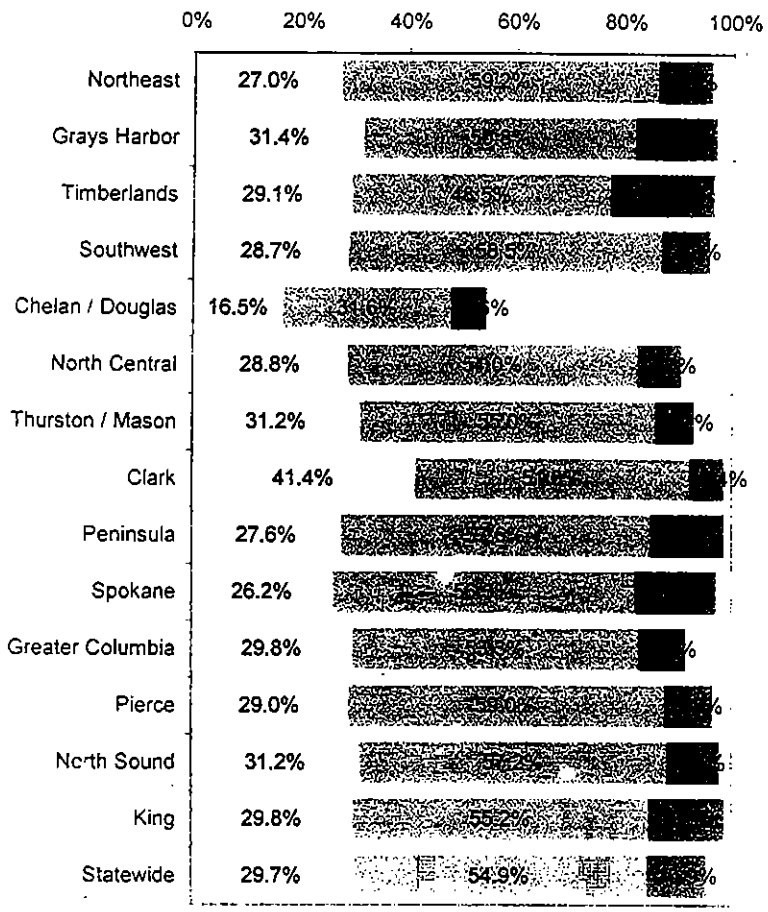
- Age is calculated as of July 1 each fiscal year.
- The State Total is unduplicated clients across all RSNs (i.e., each person is only counted once in the state).
- The RSN count shows the number of unduplicated clients within each RSN (i.e., one person is counted in <u>each</u> RSN in which they received services).
- Target Period includes July 1, 1997 through June 30, 2000.
- Counts do not include services to youth who are only served in CLIP.
- Counts are of people, not admissions or episodes.
- Data Source is Service Utilization data base (specific data set = testbig.sd2).
- Medicare data is not consistently reported.
- King RSN does not report Crisis Units. Clients who only receive Crisis Services are not counted in the number of clients served.
- Results calculated on data extracted March 2001

Access by Age *(Age Group Served / Total RSN Served)* Outpatients

/ Calc. 3/2001 SAS / **DRAFT**

Access II

	Tot Srv	FY98 Youth Served	Rate	FY98 Adult Served	Rate		
Northeast	1,580	427	27.0%	935	59.2%	157	9.9%
Grays Harbor	2,168	680	31.4%	1,101	50.8%	325	15.0%
Timberlands	2,906	846	29.1%	1,409	48.5%	556	19.1%
Southwest	2,571	738	28.7%	1,504	58.5%	227	8.8%
Chelan / Douglas	3,375	556	16.5%	1,068	31.6%	224	6.6%
North Central	2,874	827	28.8%	1,553	54.0%	231	8.0%
Thurston / Mason	4,622	1,440	31.2%	2,540	55.0%	332	7.2%
Clark	6,711	2,778	41.4%	3,423	51.0%	427	6.4%
Peninsula	5,659	1,564	27.6%	3,261	57.6%	769	13.6%
Spokane	10,047	2,629	26.2%	5,658	56.3%	1,505	15.0%
Greater Columbia	12,849	3,835	29.8%	6,844	53.3%	1,123	8.7%
Pierce	16,430	4,764	29.0%	9,688	59.0%	1,452	8.8%
North Sound	15,553	4,856	31.2%	8,893	57.2%	1,499	9.6%
King	21,493	6,401	29.8%	11,855	55.2%	2,996	13.9%
Statewide	**108,838**	**32,341**	**29.7%**	**59,732**	**54.9%**		

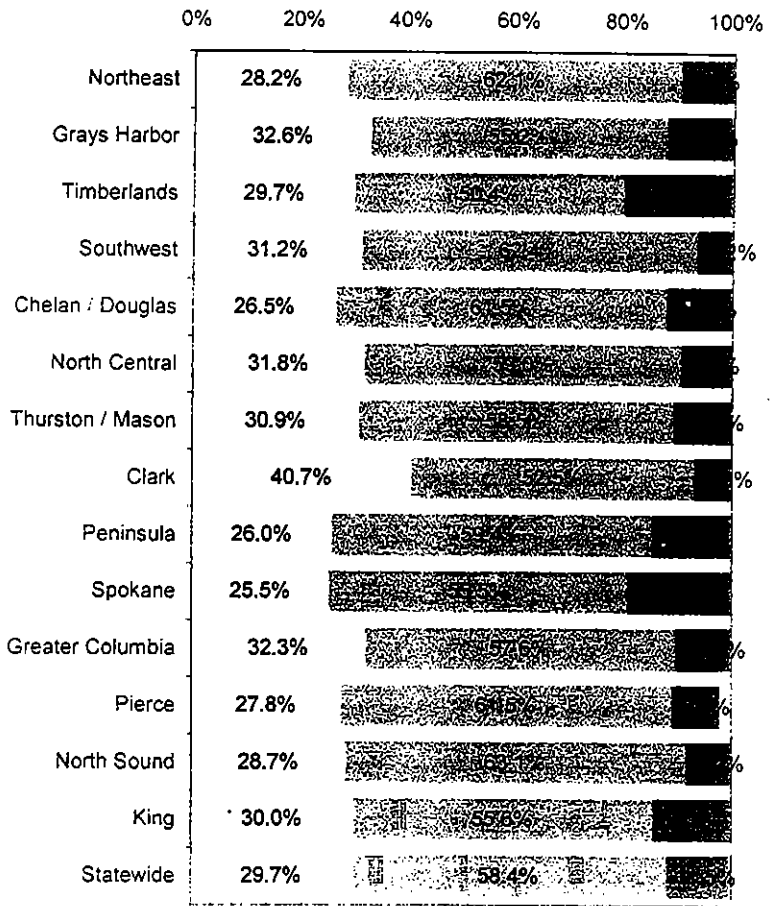


Access by Age (Age Group Served / Total RSN Served) Outpatients

/ Calc. 3/2001 SAS / **DRAFT**

Access II

		FY99 Youth		FY99 Adult			
	Tot Srv	*Served*	*Rate*	*Served*			
Northeast	1,487	420	28.2%	923	62.1%	144	9.7%
Grays Harbor	2,142	69[illegible]	32.6%	1,182	55.2%	259	12.1%
Timberlands	2,887	858	29.7%	1,455	50.4%	574	19.9%
Southwest	2,801	874	31.2%	1,747	62.4%	175	6.2%
Chelan / Douglas	2,022	535	26.5%	1,244	61.5%	243	12.0%
North Central	2,610	831	31.8%	1,539	59.0%	240	9.2%
Thurston / Mason	4,214	1,303	30.9%	2,465	58.5[illegible]	445	10.6%
Clark	6,233	2,538	40.7%	3,273	52.5%	421	6.8%
Peninsula	5,740	1,492	26.0%	3,409	59.4%	837	14.6%
Spokane	9,958	2,538	25.5%	5,524	55.5%	1,895	19.0%
Greater Columbia	11,971	3,866	32.3%	6,890	57.6%	1,209	10.1%
Pierce	17,189	4,771	27.8%	10,564	61.5%	1,503	8.7%
North Sound	17,577	5,044	28.7%	11,084	63.1%	1,441	8.2%
King	21,825	6,551	30.0%	12,138	55.6%	3,133	14.4%
Statewide	**108,656**	**32,320**	**29.7%**	**63,437**	**58.4%**		

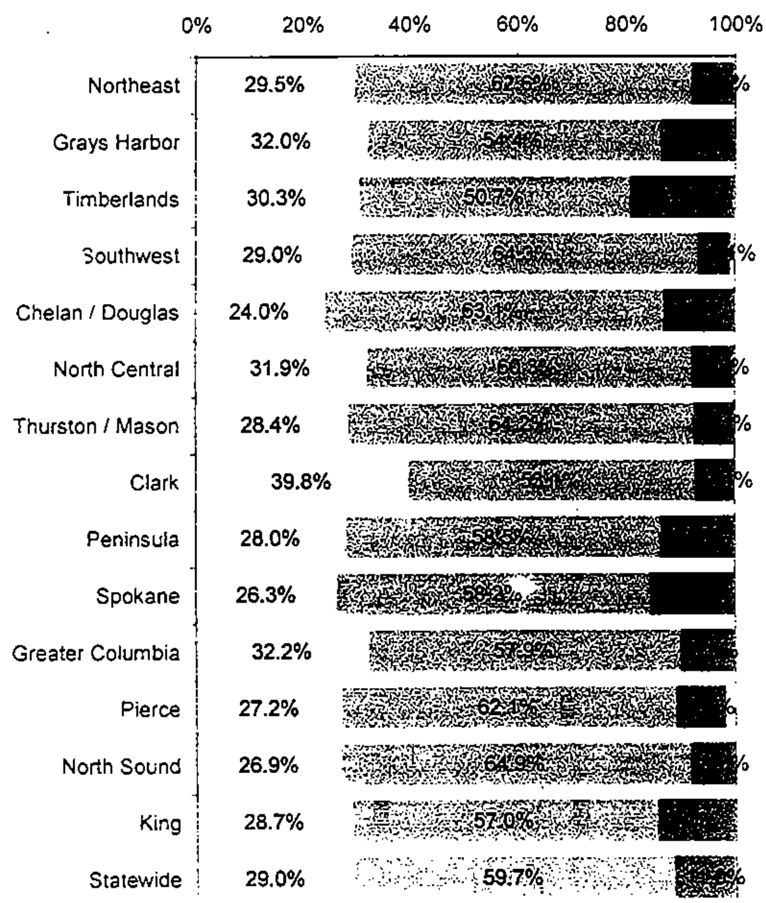


Access by Age *(Age Group Served / Total RSN Served)* ***Outpatients***

/ Calc. 3/2001 SAS / **DRAFT**

Access II

		FY00 Youth		FY00 Adult		FY00 Elder	
	Tot Srv	***Served***	***Rate***	***Served***	***Rate***	***Served***	***Rate***
Northeast	1,654	488	29.5%	1,035	62.6%	129	7.8%
Grays Harbor	2,253	720	32.0%	1,226	54.4%	306	13.6%
Timberlands	2,979	904	30.3%	1,509	50.7%	566	19.0%
Southwest	3,369	977	29.0%	2,167	64.3%	204	6.1%
Chelan / Douglas	2,323	558	24.0%	1,465	63.1%	298	12.8%
North Central	2,715	867	31.9%	1,636	60.3%	211	7.8%
Thurston / Mason	4,064	1,153	28.4%	2,611	64.2%	299	7.4%
Clark	6,345	2,526	39.8%	3,367	53.1%	448	7.1%
Peninsula	6,092	1,705	28.0%	3,563	58.5%	823	13.5%
Spokane	8,546	2,247	26.3%	4,974	58.2%	1,322	15.5%
Greater Columbia	12,019	3,871	32.2%	6,955	57.9%	1,193	9.9%
Pierce	17,296	4,697	27.2%	10,742	62.1%	1,602	9.3%
North Sound	19,543	5,263	26.9%	12,680	64.9%	1.564	8.0%
King	24,428	7,009	28.7%	13,934	57.0%	3,481	14.3%
Statewide	**113,626**	**32,985**	**29.0%**	**67,864**	**59.7%**	[illegible]	[illegible]



OUTPATIENT ACCESS IV. Average Number of Outpatient Hours per Client by Age by RSN and Statewide

Rationale for Use: The average hours of outpatient services for each client per year provides information on the amount of services received. Combined with penetration rate, the average number of hours helps understand both "how many people received a mental health service" and "how much service they received."

Examining this data by age provides an additional level of understanding of the difference in the amount of service delivered to children, adults, and elders.

Operational Measure: The average hours per client per year is calculated by dividing the total number of outpatient hours by the total unduplicated count of clients receiving Outpatient Services.

Formulas:

$$\frac{\text{Total Number of Outpatient Hours in Fiscal Year}}{\text{Number of unduplicated persons who received outpatient mental health services in Fiscal Year}}$$

$$\frac{\text{Total Number of Outpatient Hours in Fiscal Year by Age Group \{Youth, Adult, Elder\}}}{\text{Total Number of Outpatient Clients in Fiscal Year by Age Group \{Youth, Adult, Elder\}}}$$

Discussion: The first graph shows the total number of unique clients in the RSN who received Outpatient Services and the total number of hours of Outpatient Services delivered. By dividing the two numbers, the average hours of Outpatient Services per client is calculated.

Penetration rates and the proportion of mental health clients by age provide a broad understanding of the number of people who "walk in the door" and receive at least one mental health service. It does not provide information on "how much" service each client received. One RSN may have a low penetration rate (i.e., fewer clients receiving mental health services), yet deliver a lot of intensive mental health services to each client. Another RSN may have a high penetration rate, providing assessments to a large number of clients, yet deliver fewer ongoing services to clients across time.

Date of birth is calculated on July 1 of the reporting year.

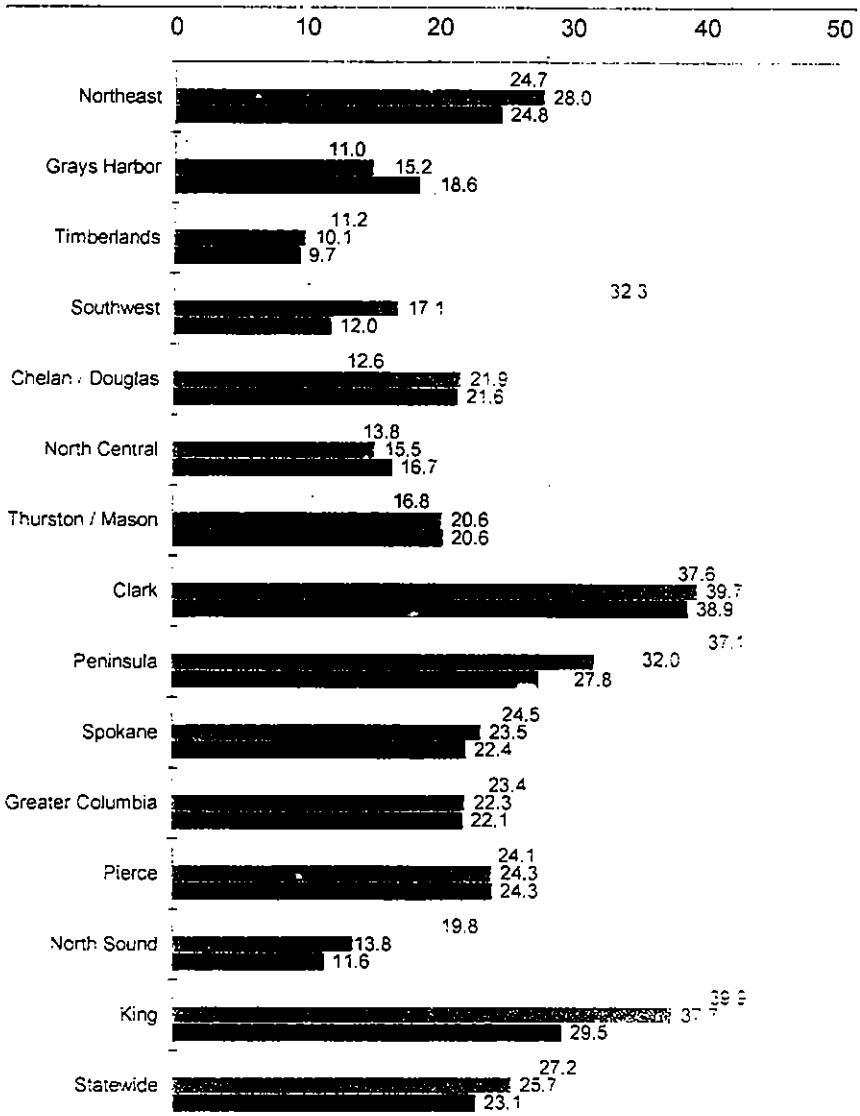
Data Notes:

- Age is calculated as of July 1 each fiscal year.
- The State Total is unduplicated clients across all RSNs (i.e., each person is only counted once in the state).
- The RSN count shows the number of unduplicated clients within each RSN (i.e., one person is counted in each RSN in which they received services).
- Target Period includes July 1, 1997 through June 30, 2000.
- Counts do not include services to youth who are only served in CLIP.
- Counts are of people, not admissions or episodes.
- Data Source is Service Utilization data base (specific data set = testbig.sd2).
- Medicare data is not consistently reported.
- King RSN does not report Crisis Units. Clients who only receive Crisis Services are not counted in the number of clients served.
- Results calculated on data extracted March 2001

Avg Hs of Service (RSN Hrs / Served) All Outpatient Service Modalities / Calc. 3/2001 SAS / DRAFT

Access IV

	FY98			FY99			FY00		
	Served	Hours	Avg Hr	Served	Hours	Avg Hr	Served	Hours	Avg Hr
Northeast	1,580	38,983	24.7	1,487	41,591	28.0	1,654	40,960	24.8
Grays Harbor	2,168	23,912	11.0	2,142	32,529	15.2	2,253	41,959	18.6
Timberlands	2,906	32,661	11.2	2,887	29,117	10.1	2,979	28,803	9.7
Southwest	2,571	83,092	32.3	2,801	47,990	17.1	3,369	40,546	12.0
Chelan / Douglas	3,375	42,516	12.6	2,022	44,314	21.9	2,323	50,256	21.6
North Central	2,874	39,783	13.8	2,610	40,391	15.5	2,715	45,437	16.7
Thurston / Mason	4,622	77,730	16.8	4,214	86,681	20.6	4,064	83,687	20.6
Clark	6,711	252,081	37.6	6,233	247,195	39.7	6,345	247,085	38.9
Peninsula	5,659	209,690	37.1	5,740	183,863	32.0	6,092	169,321	27.8
Spokane	10,047	245,714	24.5	9,958	233,839	23.5	8,546	191,099	22.4
Greater Columbia	12,849	301,100	23.4	11,971	267,254	22.3	12,019	265,775	22.1
Pierce	16,430	396,496	24.1	17,189	417,527	24.3	17,296	419,937	24.3
North Sound	15,553	308,482	19.8	17,577	243,012	13.8	19,543	226,943	11.6
King	21,493	857,372	39.9	21,825	823,766	37.7	24,428	721,015	29.5
Statewide	**106,727**	**2,901,554**	**27.2**	**106,208**	**2,731,838**	**25.7**	**112,024**	**2,583,170**	**23.1**

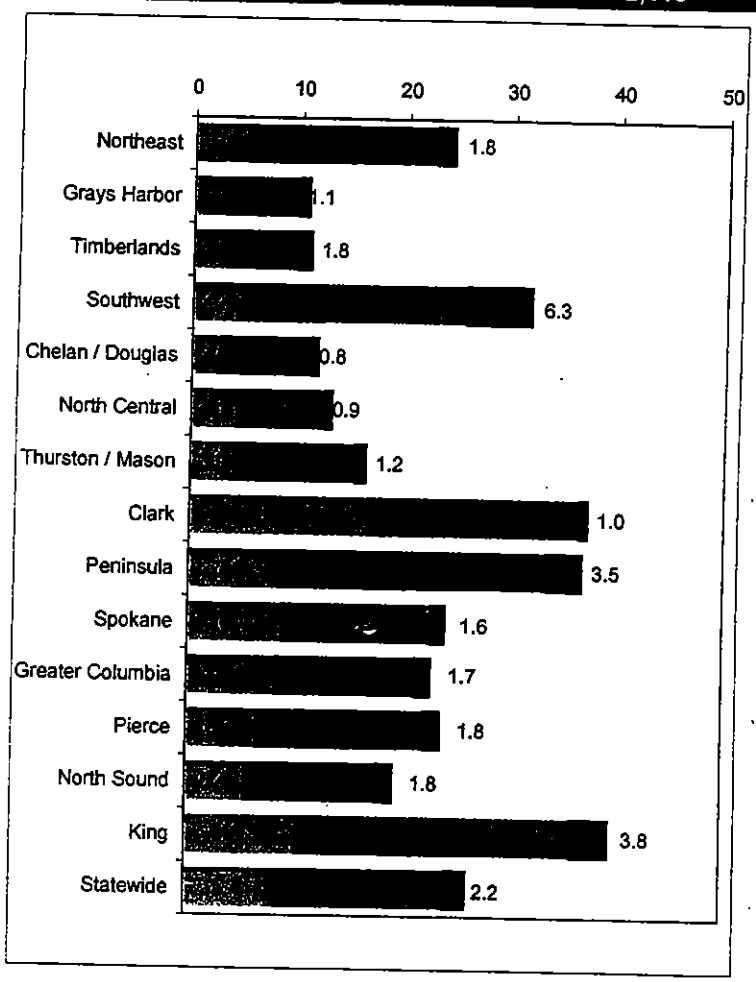


Average Hours (RSN Hrs / RSN Served) Outpatient Hrs

/ Calc. 3/2001 SAS / **DRAFT**

Access IV

	Tot Srv					FY98 Elder Hours	FY98 Elder Rate
Northeast	1,580	7,872	5.0	27,797	17.6	2,851	1.8
Grays Harbor	2,168	6,256	2.9	14,913	6.9	2,422	1.1
Timberlands	2,906	10,885	3.7	16,357	5.6	5,230	1.8
Southwest	2,571	11,280	4.4	54,399	21.2	16,308	6.3
Chelan / Douglas	3,375	8,910	2.6	28,578	8.5	2,792	0.8
North Central	2,874	11,853	4.1	24,030	8.4	2,487	0.9
Thurston / Mason	4,622	18,153	3.9	53,031	11.5	5,604	1.2
Clark	6,711	111,699	16.6	133,399	19.9	6,585	1.0
Peninsula	5,659	44,892	7.9	144,723	25.6	19,914	3.5
Spokane	10,047	87,317	8.7	140,423	14.0	16,334	1.6
Greater Columbia	12,849	104,428	8.1	169,874	13.2	21,677	1.7
Pierce	16,430	105,723	6.4	259,550	15.8	28,996	1.8
North Sound	15,553	84,545	5.4	192,950	12.4	28,576	1.8
King	21,493	221,096	10.3	552,791	25.7	82,341	3.8
Statewide	**108,838**					242,118	2.2

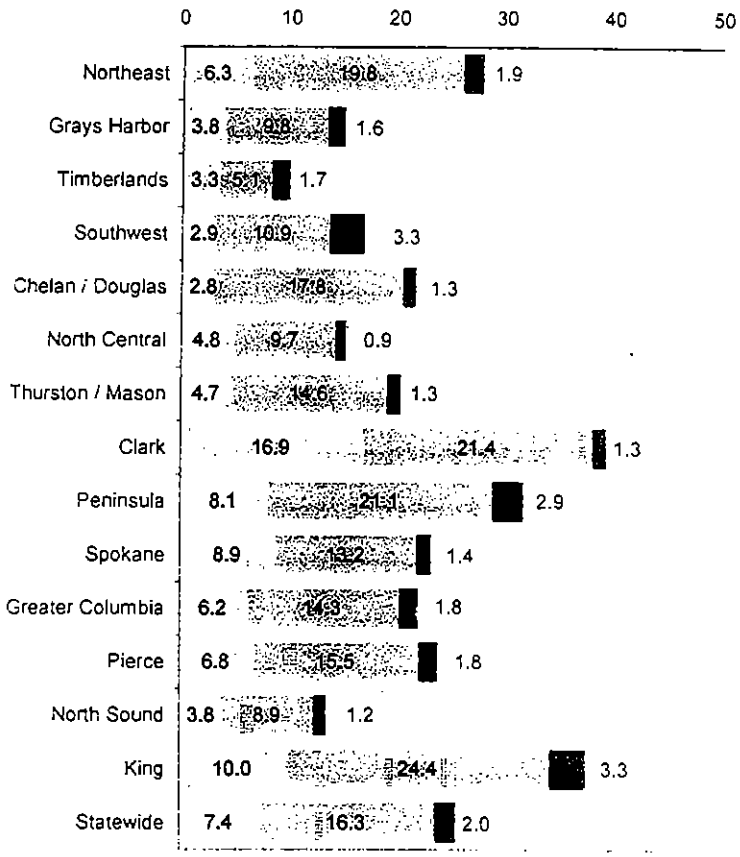


Average Hours (RSN Hrs / RSN Served) Outpatient Hrs

/ Calc. 3/2001 SAS / **DRAFT**

Access IV

	Tot Srv	FY99 Youth Hours	FY99 Youth Rate	FY99 Adult Hours	FY99 Adult Rate	FY99 Elder Hours	FY99 Elder Rate
Northeast	1,487	9,356	6.3	29,404	19.8	2,831	1.9
Grays Harbor	2,142	8,156	3.8	20,945	9.8	3,426	1.6
Timberlands	2,887	9,652	3.3	14,652	5.1	4,813	1.7
Southwest	2,801	8,143	2.9	30,611	10.9	9,172	3.3
Chelan / Douglas	2,022	5,687	2.8	36,093	17.8	2,534	1.3
North Central	2,610	12,489	4.8	25,446	9.7	2,455	0.9
Thurston / Mason	4,214	19,731	4.7	61,620	14.6	5,315	1.3
Clark	6,233	105,513	16.9	133,434	21.4	8,247	1.3
Peninsula	5,740	46,319	8.1	120,896	21.1	16,642	2.9
Spokane	9,958	88,296	8.9	131,794	13.2	13,746	1.4
Greater Columbia	11,971	74,563	6.2	171,087	14.3	21,583	1.8
Pierce	17,189	117,298	6.8	266,521	15.5	31,148	1.8
North Sound	17,577	66,024	3.8	156,306	8.9	20,659	1.2
King	21,825	217,329	10.0	533,320	24.4	73,089	3.3
Statewide	**106,208**	**788,554**	**7.4**	**1,732,129**	**16.3**	**215,661**	**2.0**

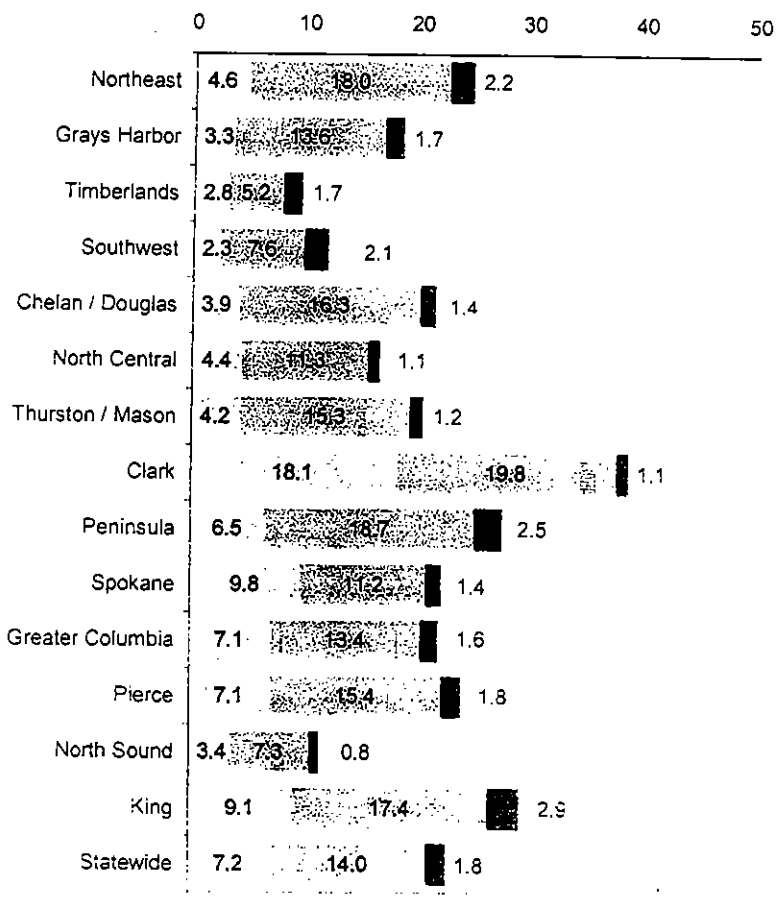


Average Hours (RSN Hrs / RSN Served) Outpatient Hrs

/ Calc. 3/2001 SAS / **DRAFT**

Access IV

	Tot Srv	FY00 Youth Hours	FY00 Youth Rate	FY00 Adult Hours	FY00 Adult Rate	FY00 Elder Hours	FY00 Elder Rate
Northeast	1,654	7,604	4.6	29,745	18.0	3,609	2.2
Grays Harbor	2,253	7,477	3.3	30,604	13.6	3,811	1.7
Timberlands	2,979	8,395	2.8	15,401	5.2	5,006	1.7
Southwest	3,369	7,774	2.3	25,504	7.6	7,210	2.1
Chelan / Douglas	2,323	9,093	3.9	37,821	16.3	3,341	1.4
North Central	2,715	11,926	4.4	30,554	11.3	2,956	1.1
Thurston / Mason	4,064	16,972	4.2	62,007	15.3	4,693	1.2
Clark	6,345	114,701	18.1	125,588	19.8	6,759	1.1
Peninsula	6,092	39,659	6.5	114,169	18.7	15,491	2.5
Spokane	8,546	83,371	9.8	95,940	11.2	11,773	1.4
Greater Columbia	12,019	84,908	7.1	161,222	13.4	19,646	1.6
Pierce	17,296	121,953	7.1	265,712	15.4	31,815	1.8
North Sound	19,543	66,980	3.4	143,363	7.3	16,569	0.8
King	24,428	223,350	9.1	426,143	17.4	71,504	2.9
Statewide	112,024	**804,163**	**7.2**	1,563,773	14.0	**204,182**	**1.8**



Average Hours (RSN Hrs / Served) Outpatient Hrs by Caucasian/Non-Caucasian / Calc. 3/2001 SAS / DRAFT

Access IV

	Caucasian			Non-Caucasian		
	FY98	FY99	FY00	FY98	FY99	FY00
Northeast	26.3	28.8	25.3	16.4	21.8	21.0
Grays Harbor	11.1	15.3	18.7	10.3	14.5	18.3
Timberlands	11.1	9.9	9.5	12.0	11.4	11.4
Southwest	34.7	17.6	12.4	17.8	13.2	9.7
Chelan / Douglas	23.6	25.0	23.3	4.3	14.6	17.7
North Central	14.7	16.2	17.6	12.1	13.6	14.4
Thurston / Mason	17.9	20.8	21.1	12.6	19.3	18.1
Clark	39.8	41.1	40.0	26.8	32.1	34.4
Peninsula	38.4	32.9	27.8	30.5	28.2	27.8
Spokane	24.8	23.4	22.4	23.0	23.7	22.3
Greater Columbia	25.9	23.1	23.0	17.7	19.9	19.2
Pierce	25.0	25.0	24.9	21.8	22.3	22.6
North Sound	23.6	17.9	13.4	13.3	8.5	8.6
King	42.1	39.4	29.5	35.6	34.6	29.6
Statewide	**28.7**	**28.3**	**24.3**	**21.5**	**21.6**	**20.8**